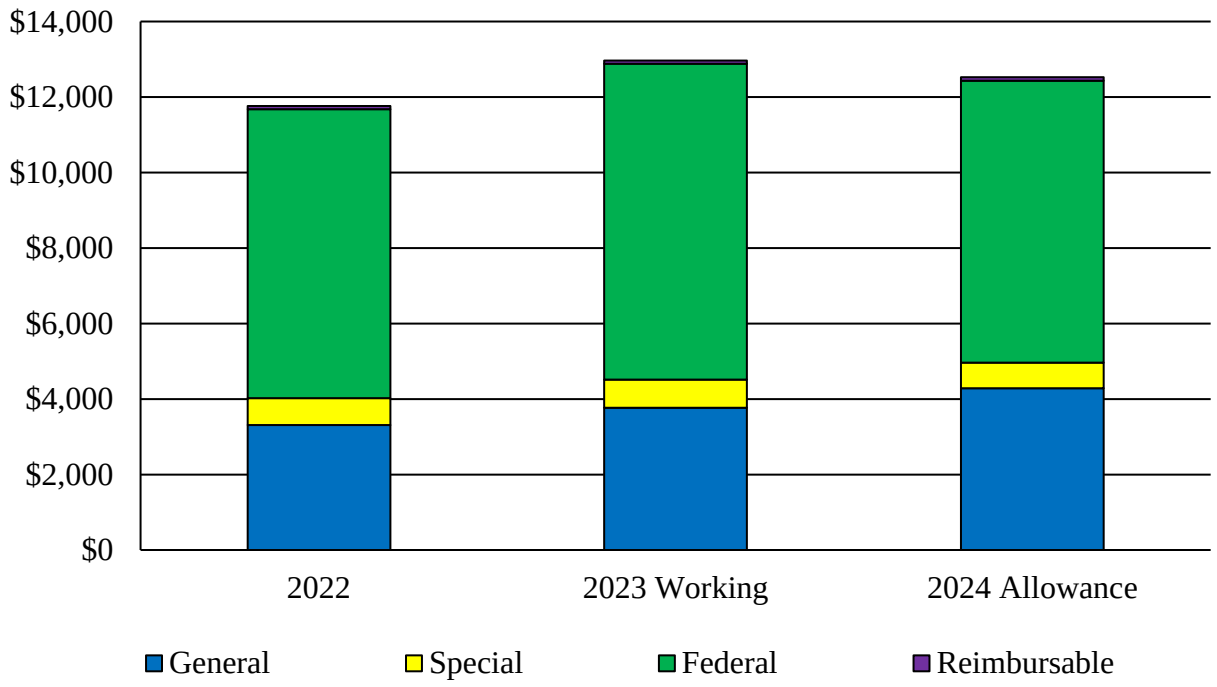
M00Q01
Medical Care Programs Administration
Maryland Department of Health

Executive Summary

The Medical Care Programs Administration (MCPA) within the Maryland Department of Health (MDH) is responsible for administering Medical Assistance (Medicaid) and the Maryland Children's Health Program (MCHP), which provide comprehensive health care coverage to indigent and medically indigent Marylanders. MCPA administers various other programs discussed in this analysis and specialty mental health and substance use disorder (SUD) services for Medicaid recipients included in the budget analysis for MDH – Behavioral Health Administration (BHA) – M00L.

Operating Budget Summary

Fiscal 2024 Budget Decreases $446.9 Million, or 3.4%, to $12.5 Billion
($ in Millions)



Note: The fiscal 2023 working appropriation includes a planned reversion and deficiency appropriations, including this agency's share of a deficiency appropriation budgeted in the Statewide Account within the Department of Budget and Management (DBM). Fiscal 2024 salary enhancements are budgeted in the Statewide Account within DBM. The fiscal 2024 allowance includes a contingent special fund reduction.

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- MCPA's adjusted fiscal 2024 allowance decreases by $446.9 million in total funds compared to the adjusted fiscal 2023 working appropriation, mainly due to projected declines in Medicaid enrollment and utilization. As a condition of receiving an enhanced federal match on qualifying Medicaid and MCHP spending during the COVID-19 public health emergency (PHE), Maryland was required to freeze disenrollment (with limited exceptions). The Consolidated Appropriations Act of 2023 set March 31, 2023, as the end date for this requirement, regardless of when the PHE terminates. As a result, the fiscal 2024 allowance anticipates a net decrease in average monthly Medicaid enrollment of approximately 10%, driving significant reductions in spending.

- General fund support for MCPA increases by just under 14% ($518.5 million) predominantly to backfill the enhanced federal matching funds. In addition to setting an end date for the continuous enrollment requirement, the Consolidated Appropriations Act of 2023 established a phase-out schedule for the enhanced federal match beginning April 1, 2023, gradually reducing the 6.2% enhanced federal matching rate each quarter until it fully expires on December 31, 2023. The fiscal 2024 allowance includes $84.4 million in anticipated federal funds from the continued enhanced match.

Key Observations

- ***Medicaid Enrollment Decline Expected as Redetermination Process Begins, Likely Overfunding Allowance:*** Maryland will resume Medicaid eligibility renewals that may lead to disenrollment on April 1, 2023. This initial redetermination process will continue over 14 months. As a result, the fiscal 2024 enrollment is expected to decrease significantly across almost all eligibility groups. The Department of Legislative Services (DLS) estimates that the fiscal 2024 allowance has a surplus in funding due to the combined impact in differences in estimates for certain eligibility categories and the total number of people that MDH has reported are known to be ineligible.

- ***Fiscal 2022 Closeout Audit Finds Significant Amount of Unsupported Federal Fund Revenue:*** Each year, the Office of Legislative Audits (OLA) conducts a review of the State's preceding fiscal year budget closeout transactions. OLA's *Statewide Review of Budget Closeout Transactions for Fiscal Year 2022* included a finding that MDH could not support the propriety of $3.5 billion in accrued federal fund revenue and did not recover $862.5 million in federal fund revenue until prompted by OLA.

- ***2022 Session Legislation Results in Significant Medicaid Coverage Expansion:*** Multiple pieces of legislation enacted in 2022 expand Medicaid benefits and otherwise administer programmatic changes that grow the program beyond current operations. For example, Chapters 302 and 303 of 2022 required Medicaid to provide certain dental services for adults effective January 1, 2023.

Operating Budget Recommended Actions

		Funds
1.	Add language restricting funds for administration until the Maryland Department of Health submits quarterly reports with data and status updates related to the Medicaid eligibility redetermination process.	
2.	Add language restricting funds for administration until the Maryland Department of Health submits a report on Medicaid rates and rate-setting studies.	
3.	Add language restricting medical care provider reimbursement funding to that purpose.	
4.	Reduce general funds within the Medicaid program and authorize a budget amendment to be processed to replace these funds with special funds in recognition of available Cigarette Restitution Fund support. This reduction in Cigarette Restitution Fund balance would maintain an estimated fiscal 2024 closing balance of $4.2 million.	-$ 15,000,000
5.	Reduce funding for Medicaid reimbursements based on reduced enrollment expectations.	-$ 115,000,000
6.	Adopt narrative requesting reports on Community First Choice Program and Home- and Community-based Options Waiver financial and registry data.	
7.	Adopt narrative requesting a report on reimbursement rates for dental services under Medicaid.	
8.	Adopt narrative requesting a report on Employed Individuals with Disabilities Program eligibility requirements.	
9.	Add language restricting Maryland Children's Health Program funding to that purpose.	
	Total Net Change	**-$ 130,000,000**

Updates

- ***Medicaid Expenditures on Abortion:*** Annual data on abortion services are provided.

- ***Medicaid Administrative Claiming for School-based Health Services:*** MDH does not currently employ an administrative claiming program for school-based services and does not anticipate doing so until the Centers for Medicare and Medicaid Services (CMS) issue updated guidance on school-based administrative claiming.

M00Q01
Medical Care Programs Administration
Maryland Department of Health

Operating Budget Analysis

Program Description

MCPA, a unit of MDH, is responsible for administering Medicaid, MCHP, the Family Planning Program, the Employed Individuals with Disabilities (EID) program, and the Senior Prescription Drug Assistance Program (SPDAP). MCPA also oversees expenditures for fee-for-service (FFS) community behavioral health services, including specialty mental health and SUD services, for Medicaid recipients. That funding is discussed in the budget analysis for BHA – M00L.

Medicaid

Medical Assistance (Title XIX of the Social Security Act), more commonly known as Medicaid, is a joint federal and state program that provides health benefits to indigent and medically indigent individuals. Based on Maryland's federal medical assistance percentage (FMAP), which varies depending on a state's per capita income relative to the national average, the federal government generally covers 50% of Medicaid costs. Medicaid eligibility is limited to children, pregnant women, elderly or disabled individuals, low-income parents, and low-income childless adults. To qualify for benefits, applicants must pass certain income and asset tests.

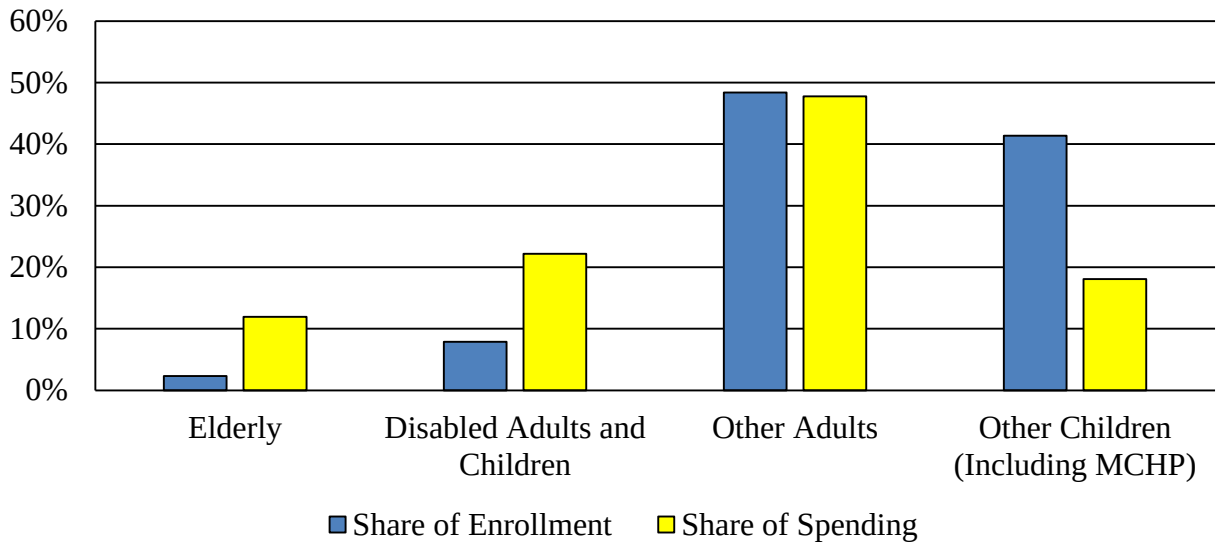
Income eligibility levels can vary based on the individual's age and pregnancy status, among other factors. Individuals receiving cash assistance through the Temporary Cash Assistance Program or the federal Supplemental Security Income (SSI) program automatically qualify for Medicaid benefits. Pregnant women can have a higher household income than other adults (up to 264% of the federal poverty level (FPL)) and qualify for Medicaid coverage. Federal law also requires the Medicaid program to assist Medicare recipients with incomes below FPL in making their coinsurance and deductible payments. Effective January 1, 2014, Medicaid coverage expanded to persons below 138% of FPL, as authorized in the federal Patient Protection and Affordable Care Act (ACA). The federal match for this population is 90%. The most current FPL guidelines are listed in **Appendix 4**.

Another major group of Medicaid-eligible individuals is the medically needy. This group includes individuals with significant health needs whose income exceeds eligibility thresholds to qualify for Medicaid but are below levels set by the State. People with incomes above the medically needy level may reduce or spend down their income to the requisite level through spending on medical care.

As shown in **Exhibit 1**, Medicaid spending does not necessarily align with each eligibility group's share of total Medicaid and MCHP enrollment. Using fiscal 2022 as an example, disabled adults and children represented only 7.9% of total enrollment, while they accounted for approximately 22.2% of medical care reimbursements. Elderly Marylanders receiving Medicaid

also accounted for a larger share of costs (12%) relative to their share of enrollment (2.3%). The medically needy population has a much more significant impact on Medicaid spending relative to their share of the Medicaid population as this group generally requires both higher cost services and higher health care utilization than other eligibility groups. Conversely, other children represent 41.4% of enrollment but only account for 18.1% of fiscal 2022 Medicaid and MCHP costs.

Exhibit 1
Relative Total Medicaid and MCHP Spending by Eligibility Category
Fiscal 2022



MCHP: Maryland Children's Health Program

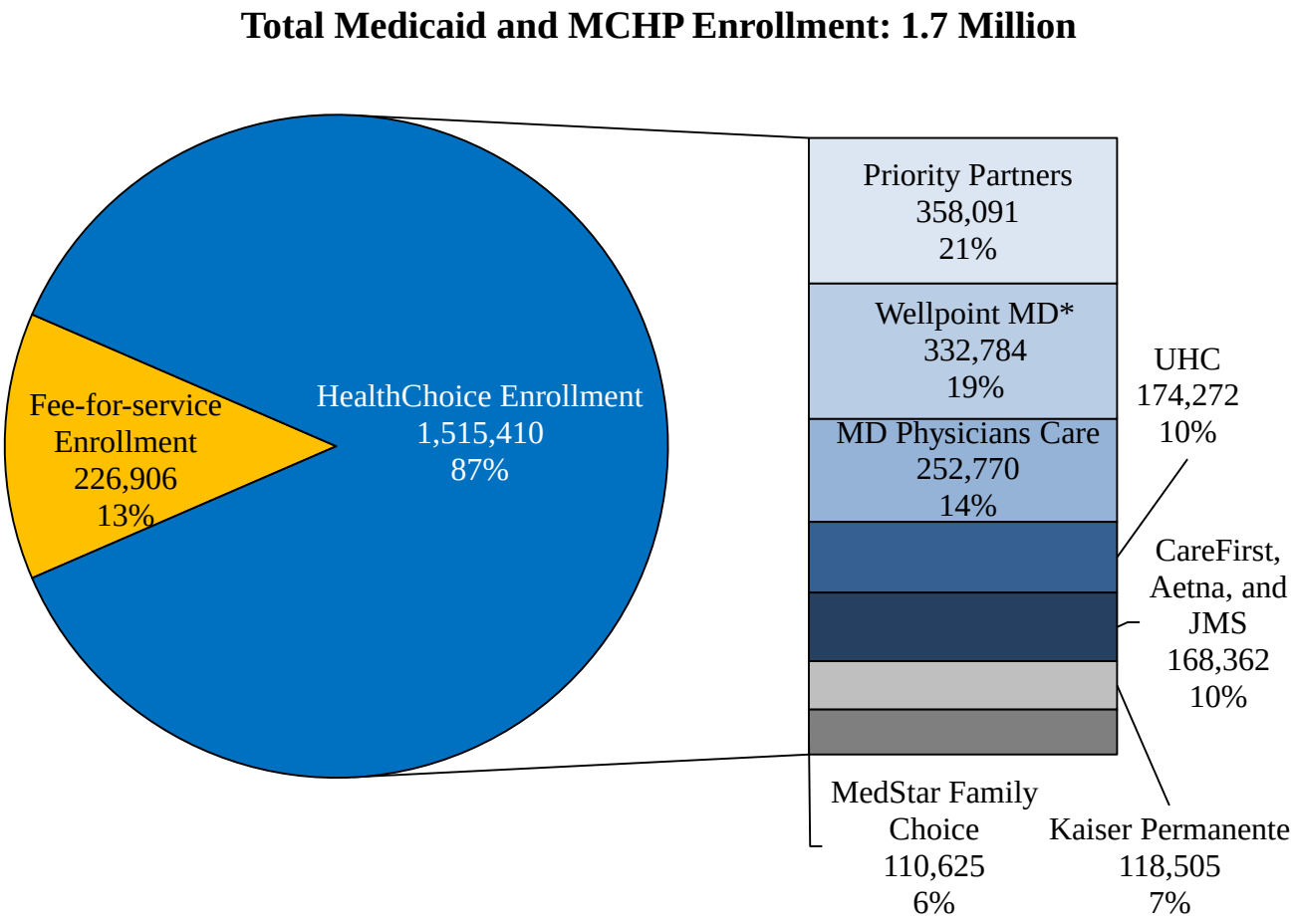
Source: Maryland Department of Health; Department of Legislative Services

Medicaid funds a broad range of services. The federal government mandates that states provide nursing facility services; hospital inpatient and outpatient services; x-ray and laboratory services; early and periodic screening, diagnosis, and treatment services; family planning services; transportation to medical care; physician care; federally qualified health center and rural health clinic services; and some nurse practitioner services. The federal government allows states to cover optional services and in Maryland, this includes, but is not limited to, vision care, pharmacy, mental health care, podiatric care, medical supplies and equipment, long-term care services, and hospice care. Effective January 1, 2023, Medicaid expanded coverage for dental services to all adult recipients (further discussed in Issue 2).

Most Medicaid recipients are required to enroll in HealthChoice, the statewide mandatory managed care program that began in 1997. As shown in **Exhibit 2**, approximately 87% of Medicaid recipients in November 2022 were enrolled in HealthChoice under one of nine managed

care organizations (MCO) operating in Maryland. In general, populations excluded from the HealthChoice program are institutionalized individuals and individuals who are dually eligible for Medicaid and Medicare. Health services for individuals not enrolled in HealthChoice are covered on a FFS basis.

Exhibit 2
Managed Care and Fee-for-service Medicaid and MCHP Enrollment
As of November 2022



*Formerly Amerigroup.

JMS: Jai Medical Systems
UHC: UnitedHealthcare

Source: Maryland Department of Health; Department of Legislative Services

MCHP

MCHP provides medical assistance for low-income children with household incomes that exceed income eligibility for Medicaid. The State is normally entitled to receive 65% federal matching funds for MCHP expenditures. Children who are eligible for MCHP are under the age of 19 and live in households with an income between the Medicaid income eligibility threshold (which varies depending on the child's age) and up to 322% of FPL. MCHP covers the same services as Medicaid. Participating families with incomes above 212% of FPL must pay a premium of about 2% of their income. DLS notes that monthly premium payments have been suspended during the national declaration of a COVID-19 PHE.

Family Planning

The Family Planning Program provides certain medical services for women who lose Medicaid coverage after being covered for a pregnancy. Covered services include medical office visits; physical examinations; certain laboratory services; family planning supplies; reproductive education, counseling, and referral; and tubal ligation. Family planning services coverage continues until age 51 with annual redetermination, unless the individual becomes eligible for Medicaid or MCHP, no longer needs birth control due to permanent sterilization, or is income-ineligible (above 264% of FPL). Enrollment in the program has declined significantly since the expansion of Medicaid eligibility under the ACA.

EID Program

The EID program extends medical assistance to working Marylanders with disabilities. Also known as the Medicaid Buy-in, this program allows disabled individuals to return to work while maintaining health benefits by paying a small fee. Individuals eligible for the EID program may make more money or have more resources than other Medicaid participants in Maryland. The services available to EID enrollees are the same as the services covered by Medicaid. The federal government covers 50% of EID program costs.

SPDAP

SPDAP provides Medicare Part D premium assistance to offset costs for moderate-income (at or below 300% of FPL) Maryland residents who are eligible for Medicare and are enrolled in certain Medicare Part D Prescription Drug Plans.

Performance Analysis: Managing for Results

1. Measures of MCO Quality Performance

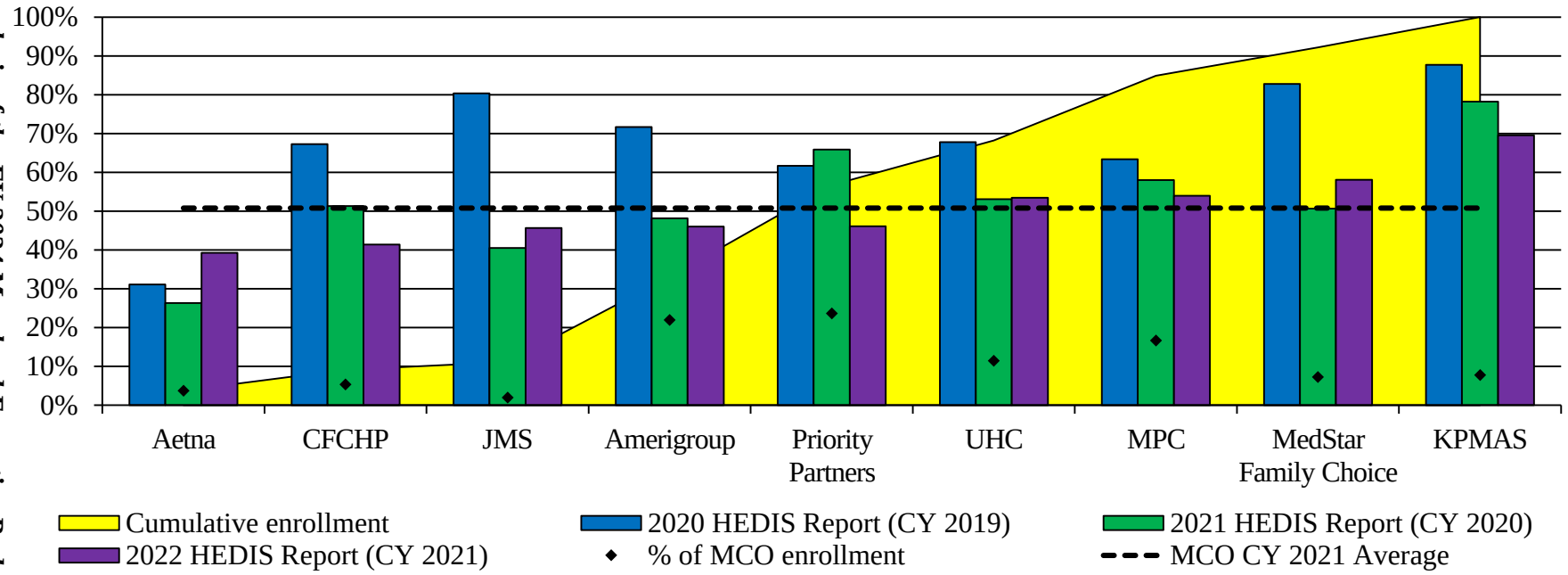
Medicaid invests significant effort in a variety of quality assurance efforts around the HealthChoice program, including:

- Healthcare Effectiveness Data and Information Set (HEDIS) data collection;
- record reviews and network adequacy testing to monitor operations;
- survey collections to evaluate enrollee and provider satisfaction;
- an annual technical report for general program management and oversight; and
- the Value-based Purchasing (VBP) program and performance improvement projects for quality measurement.

The National Committee for Quality Assurance (NCQA) developed HEDIS to measure health plan performance for comparison among health systems. This tool is used by more than 90% of health plans across the country. Calendar 2021 HEDIS data collected by MDH and published in August 2022 included 56 measures across multiple quality domains (for example, effectiveness of care and access or availability of care) and consumer assessment scores. Some measures have multiple components. The department uses a slightly smaller set of measures and components for MCO quality monitoring than the total HEDIS measures collected. This analysis uses the smaller data set provided by MDH, which consists of 44 measures in calendar 2021.

Exhibit 3 shows the percentage of measures at or above the national HEDIS mean for those components for which a national HEDIS mean was available and an individual MCO had a HEDIS score. Historically, Maryland's MCOs collectively outperform their peers nationally, but the MCO average has recently decreased from the 69% of measures equal to or above the national mean seen in calendar 2019. Maryland MCOs reached or surpassed the national HEDIS mean on only 52.6% and 50.8% of HEDIS measures monitored by MDH in calendar 2020 and 2021, respectively.

Exhibit 3
Percent of Measures Equal to or Above National HEDIS Mean And Shares of MCO Enrollment
Calendar 2019 to 2021, Enrollment as of November 2022



CFCHP: CareFirst Community Health Plan Maryland
CY: calendar year
HEDIS: Healthcare Effectiveness Data and Information Set
JMS: Jai Medical Systems
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MCO: managed care organization
MPC: Maryland Physicians Care
UHC: UnitedHealthcare

Note: Some HEDIS measures/components used in this analysis were not applicable to certain MCOs based on the small number of patients included in the measure/component. For the purpose of calculating relative performance, those measures are excluded for that MCO. Amerigroup changed its name to WellPoint Maryland but was still referred to as Amerigroup from calendar 2019 through 2021.

Source: Maryland Department of Health; MetaStar, Inc.; Hilltop Institute; Department of Legislative Services

All MCOs, with exception to Aetna Better Health of Maryland, reported significantly smaller shares of outcomes meeting or surpassing the national mean in calendar 2020 and 2021 compared to calendar 2019. It should be noted that Aetna still had the lowest share of HEDIS components meeting or surpassing that national mean in all three calendar years shown despite the improved performance in calendar 2021. Three MCOs previously reported more than 80% of HEDIS components at or above the national mean in calendar 2019, but no MCOs have reached that level since then. Five MCOs reported further declines in the percent of their outcomes meeting or surpassing the national mean between calendar 2020 and 2021. Although these results coincide with the COVID-19 PHE, all other health plans included in the national mean were also facing COVID-19 pandemic impacts at the same time. **MDH should explain why most Maryland MCOs reported significantly worse outcomes versus the national HEDIS mean in calendar 2020 and 2021 compared to calendar 2019 including any reasons that Maryland MCOs may have been disproportionately impacted by the COVID-19 pandemic compared to other health plans.**

The exhibit also displays the relative and cumulative shares of MCO enrollment as of November 2022. In November 2022, 57% of HealthChoice enrollees were served in MCOs that fell below the State average performance in calendar 2021. Priority Partners and Amerigroup, the two MCOs serving the largest market share of enrollees, both experienced worse HEDIS outcomes than the statewide average in calendar 2021, with both MCOs reporting 46% of components meeting or surpassing the national mean. Kaiser Permanente and MedStar Family Choice, the two top performing MCOs in calendar 2021, served only 15% of all Medicaid enrollees.

Accreditation

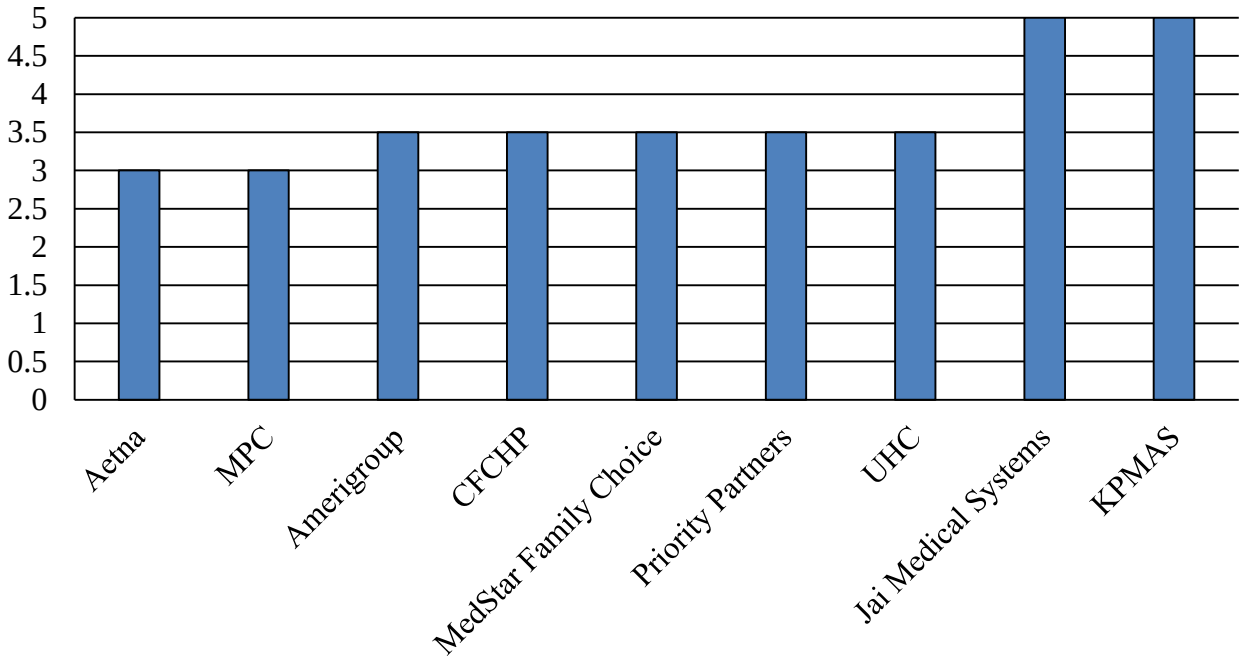
Beginning January 1, 2015, all MCOs were required to be accredited by NCQA to participate in the HealthChoice Program. New MCOs must receive accreditation within two years of program entry. NCQA formerly used a tiered structure of accreditation levels ranging from "denied" at the lowest level to "excellent" at the highest level. These levels were determined through a 100-point system valuing certain standards, performance, and consumer experience. Beginning in the 2020 Health Plan Accreditation standards year, performance scoring is separate from standards scoring, and MCOs will receive a rating and accreditation. All nine MCOs operating in Maryland were granted accreditation in calendar 2021.

Rating

NCQA implemented a new star rating system, with one star designating the lowest performance and five stars designating the highest performance, to replace the previous numeric rating system. Calendar 2021 was the first year that NCQA published MCOs' results. The overall star rating is based on the weighted average of all measures that NCQA tracks for performance scoring across three composites: patient experience; prevention; and treatment. For example, patient experience assesses patient-rated experience of care with doctors and customer service and prevention measures assess the proportion of eligible members receiving preventive services, such as immunizations, prenatal care, and cancer screenings. Measures and composites are scored from zero to five with the potential for half point results. As shown in **Exhibit 4**, all Maryland MCOs

received at least three stars for their overall ratings, and two MCOs (Kaiser Permanente and Jai Medical Systems) received five-star ratings in the first year of the new system.

Exhibit 4
NCQA Health Plan Overall Star Ratings for Maryland MCOs
Calendar 2021



CFCHP: CareFirst Community Health Plan Maryland
KPMAS: Kaiser Permanente of the Mid-Atlantic States
MCO: managed care organization
MPC: Maryland Physicians Care
NCQA: National Committee for Quality Assurance
UHC: UnitedHealthcare

Note: Amerigroup changed its name to WellPoint Maryland but was still referred to as Amerigroup in calendar 2021.

Source: *Statewide Executive Summary Report HealthChoice Participating Organizations HEDIS MY 2021 Results*; MetaStar, Inc.; Department of Legislative Services

2. Results of VBP Program in Final Year

The most visible HealthChoice quality assurance program has been the VBP, which was established in 1999 as a pay-for-performance effort. The goal of VBP was to improve MCO

performance by providing monetary incentives and disincentives up to 1% of each MCO's total capitated payments based on performance in certain health care measures identified by MDH. Under the VBP program (as detailed in Section 15-103.7 of the Health-General Article) there was a primary distribution in which MCOs with scores exceeding certain targets established by MDH received an incentive payment, while MCOs with scores below a minimum target paid a penalty. There was also a neutral range in which an MCO receives no incentive payment but does not pay a penalty. Similarly, plans that do not have a sufficient population for any particular measure could not earn an incentive or be penalized.

Incentive and penalty payments for each measure were equal up to a certain share of 1% of the total capitation paid to an MCO during the measurement year based on the number of measures selected by MDH. Total penalty payments were not to exceed 1% of the total capitation paid to an MCO in that year. The penalty payments were meant to be used to fund the incentive payments, making the program budget neutral if implemented as in statute. If collected penalties exceeded incentive payments, the surplus was distributed through a secondary distribution in the form of a bonus to the four highest performing MCOs using normalized scores and relative enrollment. Chapter 538 of 2020 (the Budget Reconciliation and Financing Act (BRFA)) restructured the secondary distribution methodology under the VBP program, as discussed in the following section.

Actuarially Sound Rate Requirement Prevents MDH from Charging Disincentives

Federal MCO regulations require actuarial soundness of rates not on a programwide basis but on an individual MCO basis. While this interpretation has been disputed, MDH indicated that CMS confirmed that this is the intent of the rule. To the extent that rates are set at the bottom of the rate range, disincentives in VBP would take an individual MCO below an actuarially sound level. As a result, VBP cannot operate as currently constituted in years that the rates are set at the bottom of the rate range.

In calendar 2018 with rates at the bottom of the range, Medicaid announced the program would be incentive only. However, because regulations were not changed, this ruling was contested. Ultimately, Medicaid settled with three MCOs on a percentage of the secondary distribution that would have been owed. MDH has also adjusted the disincentive payments from 1% to lower percentages to maintain actuarially sound rates, as occurred in calendar 2020 when MDH charged only up to 0.5% of capitated payments. MDH used additional State and federal funding to backfill the disincentive payments that it did not collect that year to pay the earned incentive payments. In calendar 2021, MDH could again not collect disincentives for VBP performance because MCO rates were set at the bottom of the range to be considered actuarially sound. Regulations and the department's calendar 2021 contract with MCOs both specified that disincentives would not be collected if it would impact actuarial soundness.

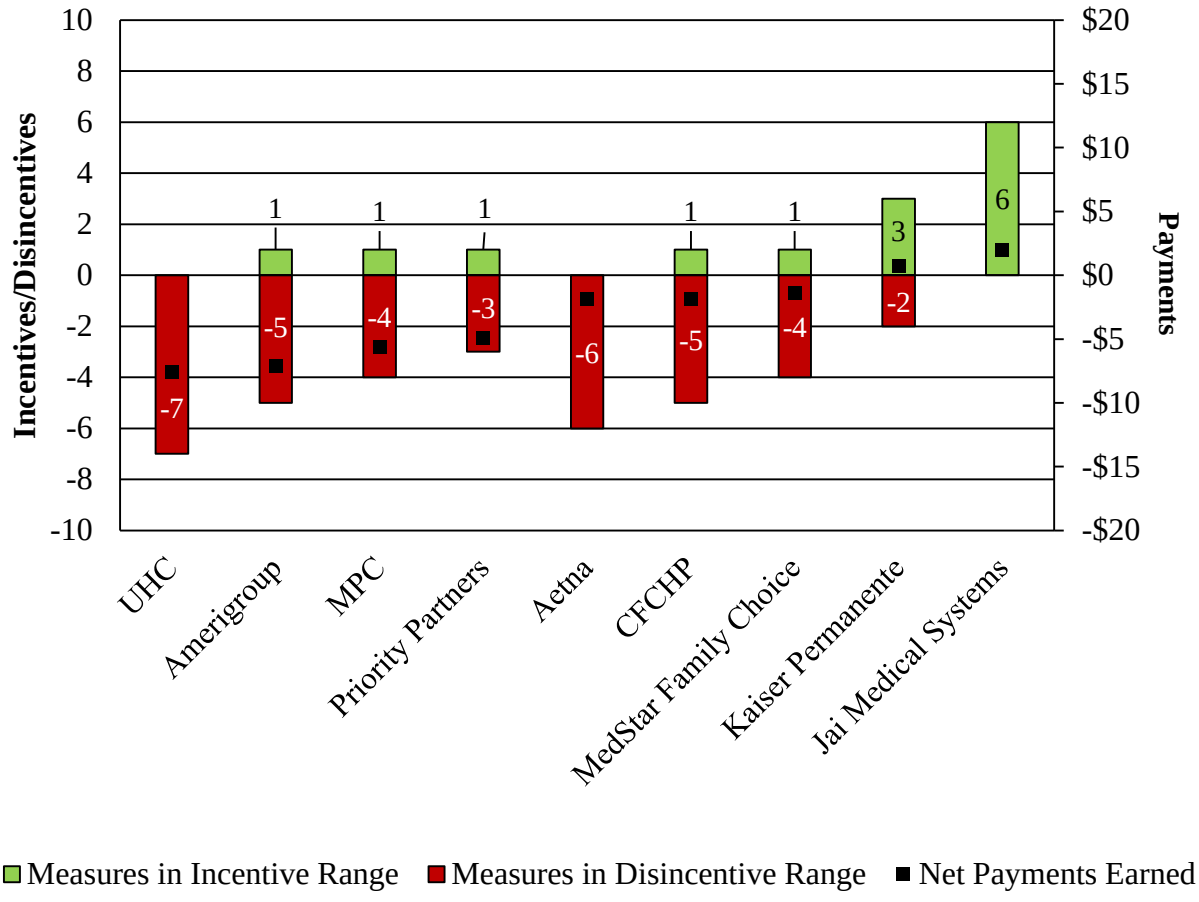
Calendar 2021 Performance

In calendar 2021, the following seven measures were chosen for consideration in VBP to determine incentives and disincentives:

- ambulatory care visits for SSI adults;
- ambulatory care visits for SSI children;
- asthma medication ratios;
- breast cancer screening;
- comprehensive diabetes care (HbA1c control of less than 8.0%);
- lead screenings for children (ages 12 months to 23 months); and
- prenatal and postpartum care.

As shown in **Exhibit 5**, seven of nine MCOs would have paid disincentives to MDH after reporting fewer outcome measures in the incentive range than measures in the disincentive range. Across all MCOs, the department is not collecting $30.5 million in disincentives that would have been owed but is paying $2.7 million in earned incentives to two MCOs through its primary distribution. In calendar 2021, disincentives would have outpaced incentives by $27.8 million, which would have been used to pay for the secondary distribution.

Exhibit 5
Results of Value-based Purchasing
Calendar 2021
($ in Millions)



CFCHP: CareFirst Community Health Plan
MPC: Maryland Physicians Care
UHC: UnitedHealthcare

Note: As a result of rates being set at the bottom range of actuarial sound levels, the Maryland Department of Health did not collect any net disincentives from managed care organizations but continued to pay the primary distribution of incentives. Net payments earned includes only the primary distribution because the Maryland Department of Health has not published a secondary distribution calculation. Amerigroup changed its name to WellPoint Maryland but was still referred to as Amerigroup in calendar 2021.

Source: Maryland Department of Health

Prior to calendar 2021, MDH paid out the secondary distribution of bonuses to the four highest performing MCOs using normalized scores and relative enrollment, which resulted in the perverse result that an MCO with more disincentives than incentives on VBP targets could still benefit as one of the "top four" performers. MedStar Family Choice and CareFirst Community Health Plan were the third and fourth top performers in calendar 2021, but also reported totals of three and four net disincentives, respectively, and would have received bonuses under this calculation. This process also provided substantial payouts to smaller MCOs despite their smaller share of overall enrollment.

In response to longstanding concerns about the secondary distribution, Chapter 538 (the BRFA of 2020) restructured the VBP program to allocate the secondary distribution as follows for measurement years beginning January 1, 2021:

- 40% to the four highest performing MCOs, except that MCOs with net disincentives could not collect funding;
- 25% to MCOs based on improvement to be used to further target performance improvement;
- 25% for health improvement programs in HealthChoice; and
- 10% to establish a reserve in the HealthChoice Performance Incentive Fund, although once the fund balance exceeds $5 million, this funding would be distributed between the other funding priorities.

Unlike prior year VBP final reports, the *Value-Based Purchasing Final Report for Calendar 2021*, submitted in February 2023, provided only the net payments shown per MCO from the primary distribution and did not outline the calculation for the secondary distribution. As a result, it is not clear whether MDH implemented the secondary distribution method as required in the BRFA of 2020. Despite disincentives not being collected due to the actuarially sound rates rule, funding should be available for a secondary distribution because the fiscal 2023 working appropriation includes $35 million for the VBP program calendar 2021 results. Only $30.5 million would be needed for calendar 2021 incentives and bonuses ($2.7 million for incentives provided in the primary distribution and $27.8 million for bonuses paid through the secondary distribution), leaving a balance of $4.5 million.

MDH should clarify whether it is implementing a secondary distribution under the VBP program for calendar 2021 results using (1) the required methodology outlined in the BRFA of 2020 and (2) budgeted funds in fiscal 2023 to account for foregone disincentive payments. The department should also provide total net payments for each MCO and incentive and bonus payments by MCO for each distribution round separately. Finally, MDH should discuss how it plans to spend the minimum $4.5 million in remaining VBP funds if a secondary distribution is administered and up to $27.8 million in remaining funds if a secondary distribution is not administered.

VBP Sunset and Population Health Incentive Program Implementation

Rather than implementing all of the VBP program changes detailed in the BRFA of 2020 beyond calendar 2021, Medicaid replaced VBP with the HealthChoice Population Health Incentive Program (PHIP), effective January 1, 2022. PHIP includes an incentive-only structure. PHIP will continue the practice of awarding incentive payments to MCOs in two rounds and will incorporate some of the changes to VBP from the BRFA of 2020, such as adding improvement-based payments. Under this program, the level of incentives available will be based on the amount provided in the budget for each fiscal year.

As described in regulations, the new program would allow MCOs to receive performance incentives or improvement incentives in the first round.

- ***Performance Incentive Payments:*** MCOs could earn payments for achieving incentives ranked from "strong performance" (in which a measure is between the fiftieth and seventy-fourth percentile of national HEDIS performance or Maryland MCO performance for non-HEDIS measures) to "superlative performance" (in which an MCO is at or above the ninetieth percentile of national HEDIS performance or Maryland MCO performance for non-HEDIS measures). Depending on the incentive category achieved, MCOs would earn higher or lower incentive allocations, and MCOs earning a score below the fiftieth percentile would not be eligible for a round one performance payment for that measure.

- ***Improvement Incentive Payments:*** If an MCO (1) demonstrates improvement of at least 0.5 percentage points for a measure over the prior year and (2) reports a score at least in the fiftieth percentile of national HEDIS performance or Maryland MCO performance for non-HEDIS measures, then it may also earn a share of the incentive allocation for that measure

MDH would implement a second round of PHIP payments if there are remaining funds unallocated after the initial round. However, MCOs would only be eligible for a secondary payment if it earned above 80% of possible round one incentives and did not have any penalties applied for failure to meet HEDIS monitoring policies. The fiscal 2024 allowance includes $36 million ($12.8 million in general funds and $23.2 million in federal funds) for this program and will be used for calendar 2022 performance.

Fiscal 2023

Planned Reversion Related to Accrual

Under the Medicaid program, FFS claims can be submitted up to a year after the service has been delivered. At the end of each fiscal year, Medicaid accrues unspent funds to pay for

anticipated Medicaid bills received in the following fiscal year but are charged back to the prior year. The fiscal 2024 budget plan assumes a reversion of $9.7 million to account for accrued funds that will not be needed to cover fiscal 2022 Medicaid claims. This reversion would occur during the fiscal 2023 closeout.

Proposed Deficiency

Proposed deficiency appropriations provide a net increase of $720.4 million in total funds supporting fiscal 2023 Medicaid and MCHP expenditures. This increase is driven by $960.0 million in federal funds that are partially offset by a net reduction of $235.0 million in general funds. Deficiencies were added for the following purposes:

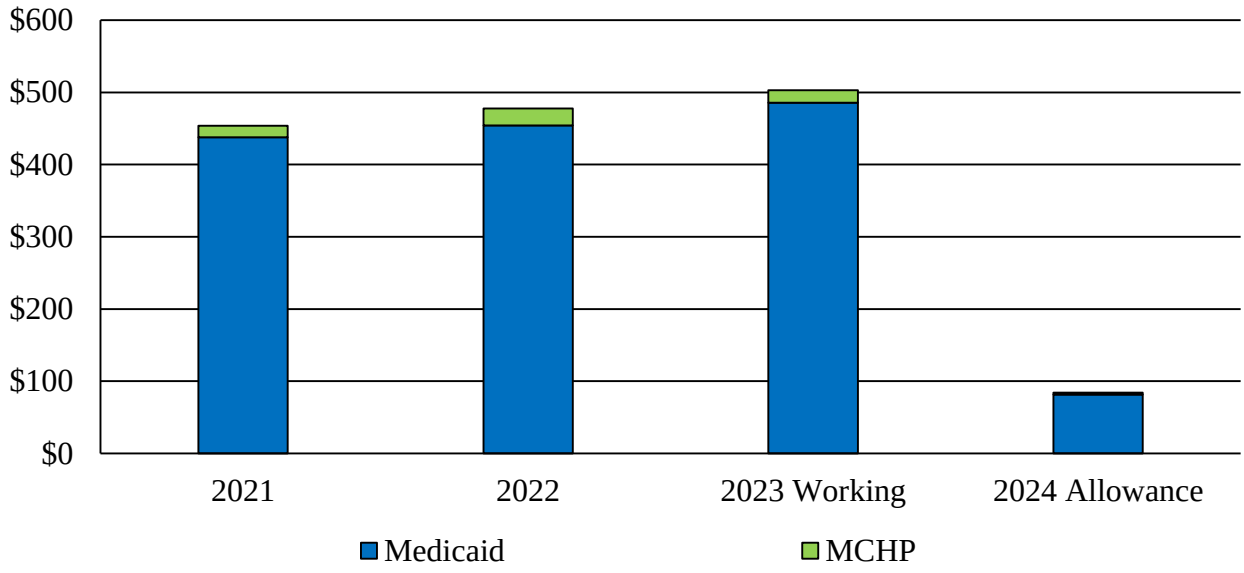
- $720.4 million in total funds to adjust enrollment, utilization, and rate assumptions ($267.9 million in general funds, $457.1 million in federal funds, and $2.6 million in reimbursable funds, partially offset by a reduction of $7.1 million in special funds). These added costs are driven by increased enrollment and utilization projections resulting from the continuous enrollment requirement being extended through March 31, 2023. Special funds are reduced due to decreases in anticipated nursing home assessment and MCHP premium revenues. During the COVID-19 PHE, MCHP premiums have been suspended. **MDH should comment on when it plans to resume collection of monthly MCHP premium payments.**

- $502.9 million in federal funds to account for enhanced federal matching funds received, which were not accounted for in fiscal 2023, because at the time of the budget enactment, the PHE was expected to end prior to fiscal 2023. The deficiency appropriations also reduce Medicaid and MCHP spending by an equivalent amount of general fund savings.

COVID-19 Enhanced Federal Match on Medicaid Spending

The Families First Coronavirus Response Act of 2020 authorized a 6.2% enhanced federal match on qualifying Medicaid expenses (4.34% for MCHP) during the national COVID-19 PHE. As shown in **Exhibit 6**, this provision led to over $450 million in annual federal assistance and equivalent general fund savings across Medicaid and MCHP in fiscal 2021 and 2022, excluding specialty behavioral health services and services for individuals with developmental disabilities covered by Medicaid. Proposed deficiencies in MCPA add a total of $502.9 million in federal funds and remove general fund savings for anticipated enhanced federal matching funds claimed in fiscal 2023.

Exhibit 6
COVID-19 Enhanced Federal Match on Medicaid and MCHP Expenses
Fiscal 2021-2024 Allowance
($ in Millions)



MCHP: Maryland Children's Health Program

Note: All COVID-19 enhanced federal matching funds across the Maryland Department of Health's fiscal 2023 working appropriation are added through deficiency appropriations. Enhanced federal funds claimed on specialty behavioral health services and services for individuals with developmental disabilities covered by Medicaid are included in the budget analyses for Behavioral Health Administration – M00L and Developmental Disabilities Administration – M00M, respectively.

Source: Department of Budget and Management; Maryland Department of Health

Initially, the enhanced FMAP was set to end in the last quarter in which the national COVID-19 PHE ends. However, the Consolidated Appropriations Act of 2023 established a phase-out schedule that reduces the 6.2% enhanced match each quarter, beginning April 1, 2023, until the match fully expires on December 31, 2023. The fiscal 2024 allowance includes $84.4 million in federal funds and equivalent general fund savings across Medicaid and MCHP, as the enhanced FMAP phases out in the first two quarters.

American Rescue Plan Act Federal Funding Supports Provider Assistance in Fiscal 2023

A fiscal 2023 budget amendment signed by Governor Lawrence J. Hogan on January 9, 2023, increased MCPA's federal fund appropriation by $75.0 million to distribute assistance to certain health plans and facilities operating in Maryland. This funding came from the State Fiscal Recovery Fund authorized in the American Rescue Plan Act (ARPA) and provides:

- $50 million for Medicare Advantage plans operating in Maryland with allocations based on each plan's proportion of total enrollment in Baltimore City and Baltimore County. This one-time funding aims to stabilize the market and uses funds through the ARPA revenue loss provision; and

- $25 million to skilled nursing facilities to help pay for increased expenses for staffing, supplies, testing, and therapeutics resulting from the COVID-19 pandemic.

MDH should provide an update on how the ARPA funds supporting Medicare Advantage plans and skilled nursing facilities have been distributed and the timeframe for spending the funds.

MCO Risk Corridor Agreements and State Recoveries

The COVID-19 pandemic led to lower health care service utilization in calendar 2020, causing MCOs to spend less relative to their capitated payments. Medicaid traditionally relies on the Medical Loss Ratio (MLR) requirement that 85% of capitated payments are spent on qualifying medical expenses to recoup underspending. Given the uncertainty around service utilization trends throughout the pandemic, CMS allowed states to retroactively enter risk-sharing arrangements, and MDH established two-sided risk corridor arrangements with MCOs to share in both savings and losses. MDH has incorporated risk corridor arrangements into MCOs' annual contracts in calendar 2020, 2021, and 2022. One exception is that Kaiser Permanente was excluded from the risk corridor arrangement in both years (as it is in regular rate-setting) due to its significantly higher operating costs and disproportionate risk of losses relative to other MCOs.

The risk corridor in calendar 2020 was based on each individual MCO's experience, with MCOs falling into a band based on MLR that puts them in a specific corridor. In a response to committee narrative in the 2022 *Joint Chairmen's Report* (JCR) submitted on October 4, 2022, MDH outlined the lower bands that would provide the State with additional savings, a neutral range of MLR between 88.2% and 92.2% that would not trigger a risk corridor adjustment, and the higher bands that would require the State and federal government to help cover 50% or 75% of MCO losses.

Bands that provide the State with savings are shown in **Exhibit 7**, along with the results (based on claims paid through November 2021 and final calculations performed in June 2022) showing that five MCOs reported low enough MLRs to fall into these corridors. Under the risk corridor agreement, these MCOs must share 50% or 75% of their savings (shown as accruals) with

MDH and the federal government. Jai Medical Systems reported an MLR that placed it in a corridor in which the State and federal government shares $205,563 in extra costs for calendar 2020. This funding partially offsets total State and federal recovery for a net total of $106 million in total savings. Of this funding, MDH's share is approximately $35 million. MDH indicated in the JCR report that it had withheld funds from the MCOs based on preliminary accruals and would use the final calculated accruals to reconcile the withheld funding in August 2022. **MDH should provide an update on whether all calendar 2020 risk corridor recoveries have been reconciled and explain the timing and method for the $35 million in State recoveries to be accounted for in the MCPA budget.**

Exhibit 7
Risk Corridor Bands and Recoveries
Calendar 2020-2021
($ in Millions)

Medical Loss Ratio (MLR) Corridor Resulting in Additional Savings for MDH	State/Federal Government Share of Gain	MCO Share of Gain	Preliminary MCOs Sharing Savings	Reported Accruals
Calendar 2020				
Corridor C+: MLR of less than 86.2%	75%	25%	Aetna, Amerigroup, CFCHP, UnitedHealthcare	-$93.5
Corridor B+: MLR between 86.2% and 88.2%	50%	50%	Priority Partners	-12.6
			Total State/Federal Recovery	**-$105.9**
			Maryland Share	**-$34.9**
Calendar 2021				
Corridor C+: MLR of less than 95.29%	90%	10%	MCOs as a group are not expected to trigger calendar 2021 risk corridor	n/a
Corridor B+: 95.30% to 96.79%	50%	50%		n/a

CFCHP: CareFirst Community Health Plan Maryland
MCO: managed care organization
MDH: Maryland Department of Health

Note: Amerigroup changed its name to WellPoint Maryland but was still referred to as Amerigroup in calendar 2020 and 2021. Compared to calendar 2020, the calendar 2021 risk corridor methodology shifted from using individual MCO's experiences to using MCOs' program-wide experience.

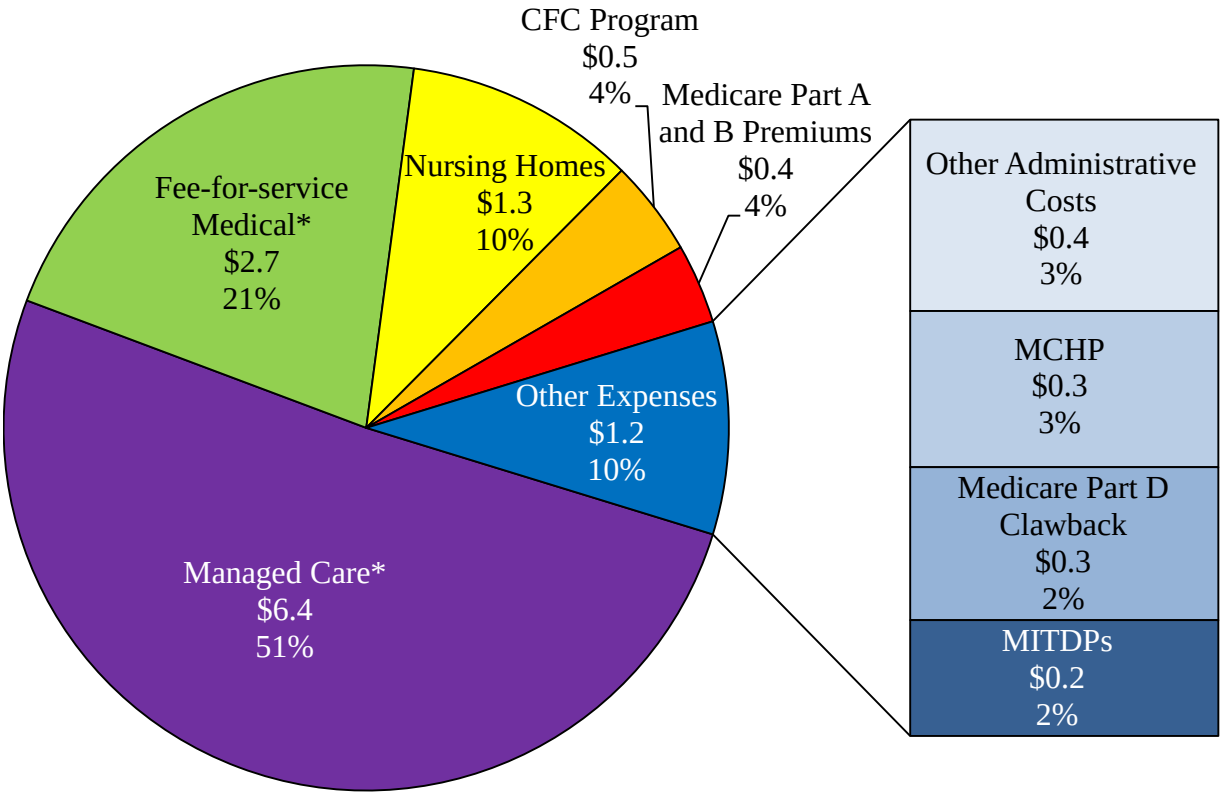
Source: Maryland Department of Health; Department of Legislative Services

Although MDH entered risk corridor agreements in calendar 2021 and 2022 as well, the methodology is slightly different, as the agreements are based on programwide experience (with Kaiser Permanente still excluded). As of October 4, 2022, when the response was submitted, MDH did not expect the calendar 2021 and 2022 risk corridors to be triggered and did not anticipate a risk corridor arrangement being in place in calendar 2023.

Fiscal 2024 Overview of Agency Spending

As shown in **Exhibit 8**, MCPA's adjusted fiscal 2024 allowance totals $12.5 billion. About half of the MCPA budget (51%, or $6.4 billion) supports reimbursements for health care services provided to Medicaid enrollees participating in the Medicaid HealthChoice program, referred to as Managed Care in the exhibit. In addition, 32%, or $4 billion, covers FFS medical costs including dental coverage and nursing home costs. Both managed care and FFS costs are adjusted downward slightly to account for a total of $696 million in pharmacy rebates that the State receives on prescription drugs purchased above a certain federally set price. Long-term care spending under the Community First Choice (CFC) program makes up 4% of the budget at $534 million. This program's share of total MCPA spending has grown over time, as long-term care services that used to be spread across multiple programs were consolidated under the CFC program.

Exhibit 8
Overview of Agency Spending
Fiscal 2024 Allowance
($ in Billions)



Total Expenditures: $12.5 Billion

CFC: Community First Choice
MCHP: Maryland Children's Health Program
MITDP: Major Information Technology Development Project

*Managed care and fee-for-service medical care reimbursements are adjusted downward to account for pharmacy rebates that Maryland receives on prescription drug purchases above a certain federally set price.

Note: Fiscal 2024 salary enhancements are budgeted in the Statewide Account within the Department of Budget and Management. The fiscal 2024 allowance includes a contingent special fund reduction and a contingent general fund appropriation.

Source: Maryland Department of Health; Department of Budget and Management; Department of Legislative Services

Proposed Budget Change

As shown in **Exhibit 9**, the fiscal 2024 allowance decreases by approximately $446.9 million compared to the fiscal 2023 working appropriation after accounting for proposed deficiency appropriations, planned reversions, contingent reductions, and MCPA's share of the 4.5% cost-of-living adjustment provided in November 2022. The net reduction in fiscal 2024 spending is largely attributed to projected decreases in Medicaid and MCHP enrollment and utilization, causing about $924 million in reduced expenditures. Provider rate increases totaling $214.7 million and an increase of $100.2 million in prescription drug expenditures resulting from lower anticipated pharmacy rebates partially offset the reduction from anticipated enrollment and utilization decline.

Exhibit 9
Proposed Budget
MDH – Medical Care Programs Administration
($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2022 Actual	$3,313,865	$707,866	$7,651,872	$87,042	$11,760,644
Fiscal 2023 Working Appropriation	3,769,920	747,945	8,366,121	85,015	12,969,001
Fiscal 2024 Allowance	4,288,456	670,613	7,473,499	89,503	12,522,070
Fiscal 2023-2024 Amount Change	$518,536	-$77,332	-$892,622	$4,488	-$446,931
Fiscal 2023-2024 Percent Change	13.8%	-10.3%	-10.7%	5.3%	-3.4%

Where It Goes:	Change
Personnel Expenses	
Employee and retiree health insurance	$1,442
Annualization of a 4.5% general salary increase that took effect November 1, 2022	703
Salaries and fringe benefits for 11 contractual conversions	599
Retirement contributions	167
Social Security contributions	110
Other fringe benefit adjustments	18
Turnover expectancy (increases from 6.61% to 6.81%)	-83
Overtime earnings	-88
Salary and wage adjustments, primarily due to setting vacant positions at base	-105

Where It Goes:	**Change**
Provider Reimbursements and Contracts	
Provider rate increases, driven by a 1.1% rate increase for MCOs	214,657
Estimated reduction in prescription drug rebates, causing higher pharmacy costs	100,159
Annualization of adult dental coverage expansion, which took effect January 1, 2023, in accordance with Chapters 302 and 303 of 2022	76,300
Community First Choice program, including $15.2 million enhancement to fund up to 4,800 enrollees	18,786
Federally Qualified Health Center supplemental payments	17,616
Medicare Part D clawback	15,708
Money Follows the Person program	13,914
Administrative contracts, including utilization review, nursing home audit, eligibility determination, and dental administrator services	9,286
Health home payments, primarily due to 3% behavioral health provider rate increase	5,929
Maryland Quality Innovation Program	5,536
Population Health Improvement Program	1,000
Senior Prescription Drug Assistance Program (special funds)	-1,043
End of COVID-19 vaccine incentive program	-5,000
Medicare Part A & B premium assistance	-6,421
Emergency Service Transporter Supplemental Payment Program	-18,000
One-time ARPA assistance for nursing homes	-25,000
Enrollment and utilization	-924,053
Other Changes	
Long Term Services and Supports Tracking System MITDP (see **Appendix 3** for more information)	80,337
Health information exchange (CRISP) support	17,871
Operating costs under the Office of Enterprise Technology	2,146
Independent case management services for the Medical Day Care waiver program	2,753
Contractual personnel expenses, driven by net increase of 55.97 FTE and annualization of a 4.5% general salary increase for contractual employees	2,535
National initiative to address COVID-19 health disparities (federal funds)	1,686
Other operating expenses	819
Maternal and Child Health Population Health Improvement fund	-2,500

Where It Goes:	**Change**
Medicaid Management Information System II MITDP (see **Appendix 2** for more information)	-4,715
One-time ARPA assistance distributed to Medicare Advantage plans in fiscal 2023 (federal funds)	-50,000
Total	**-$446,931**

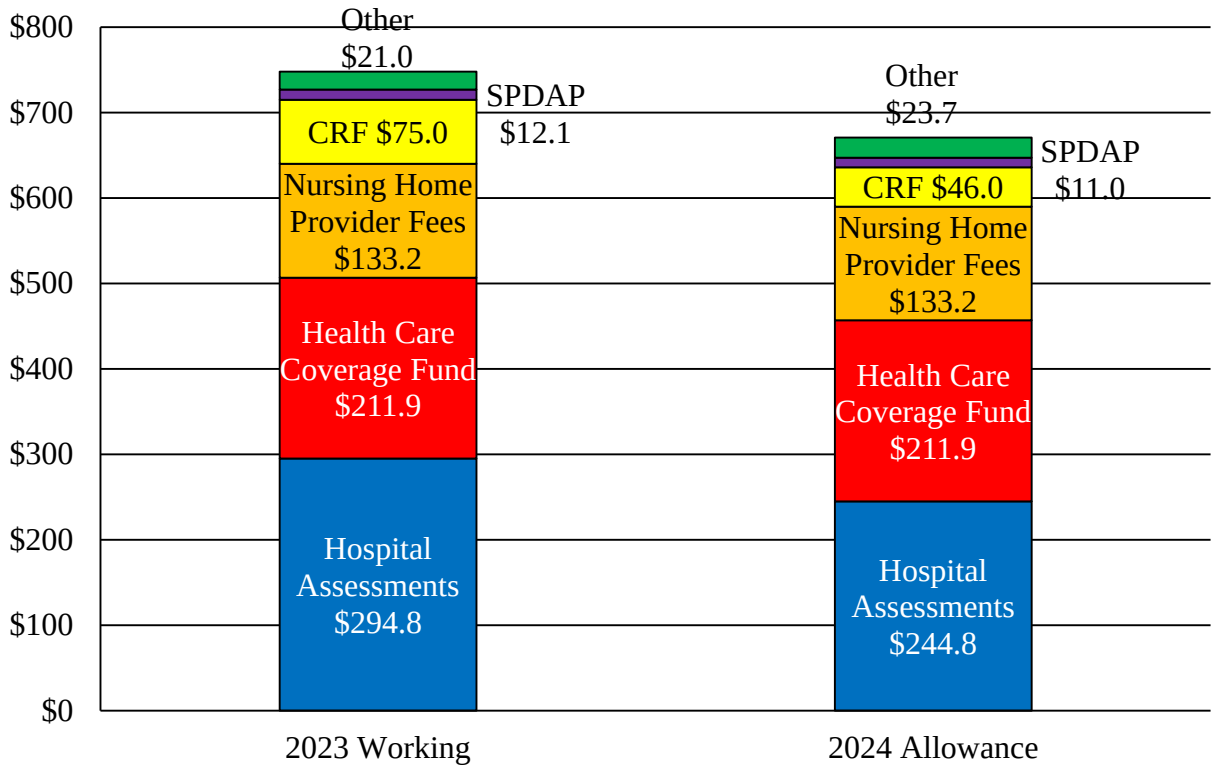
ARPA: American Rescue Plan Act of 2021
CRISP: Chesapeake Regional Information System for our Patients
FTE: full-time equivalent
MCO: managed care organization
MDH: Maryland Department of Health
MITDP: major information technology development project

Note: The fiscal 2023 working appropriation includes a planned reversion and deficiency appropriations, including this agency's share of a deficiency appropriation budgeted in the Statewide Account within the Department of Budget and Management (DBM). Fiscal 2024 salary enhancements are budgeted in the Statewide Account within DBM. The fiscal 2024 allowance includes a contingent special fund reduction. Numbers may not sum to total due to rounding.

Special Fund Availability

Exhibit 10 details a variety of special fund sources that support fiscal 2023 and 2024 Medicaid and MCHP expenditures. Overall, special fund spending under MCPA programs in the fiscal 2024 allowance decreases by $77.3 million compared to the fiscal 2023 working appropriation, largely due to a contingent reduction in the Medicaid Deficit Assessment ($50 million) and lower anticipated Cigarette Restitution Fund (CRF) spending ($29 million).

Exhibit 10
Special Fund Support for the Medical Care Programs Administration
Fiscal 2023-2024
($ in Millions)



CRF: Cigarette Restitution Fund
SPDAP: Senior Prescription Drug Assistance Program

Note: The fiscal 2023 working appropriation includes deficiency appropriations, including this agency's share of a deficiency appropriation budgeted in the Statewide Account within the Department of Budget and Management (DBM) accounted for in the other special fund category. Fiscal 2024 salary enhancements are budgeted in the Statewide Account within DBM. The fiscal 2024 allowance includes a contingent reduction.

Source: Governor's Fiscal 2024 Budget Books

Contingent Action Related to the Medicaid Deficit Assessment

The fiscal 2024 allowance assumes that $50 million in general funds will backfill an equivalent reduction in special funds from the Medicaid Deficit Assessment. Both actions are contingent on the passage of HB 202/SB 182 of 2023 (the BRFA). During the great recession, a Medicaid Deficit Assessment was imposed on Maryland hospitals to support the Medicaid program. The assessment consists of (1) an amount included in hospital rates (and paid by hospital

users) and (2) a remittance from hospitals. The BRFA of 2023 would reduce the Medicaid Deficit Assessment from $294.8 million to $244.8 million in fiscal 2024 only.

This action lowers hospital spending by $50 million overall to assist the State in meeting Medicare savings and expenditure growth targets required in the Total Cost of Care (TCOC) model. A detailed discussion of the TCOC model and Maryland's performance on Medicare spending targets can be found in the budget analysis for MDH – Health Regulatory Commissions – M00R01. The Medicaid Deficit Assessment reduction is just one corrective action proposed to improve model performance, and the Health Services Cost Review Commission (HSCRC) is in the process of implementing other cost saving measures generally related to hospital rate setting activities.

HSCRC is pursuing a corrective action that lowers Medicare hospital costs in Maryland by increasing the public payer differential by 1% through fiscal 2024. Under the existing public payer differential, Medicare and Medicaid pay 7.7% less than other payers in hospital rates due to business practices that avert bad debt in hospitals to keep Maryland's costs low. A 1% increase to the differential is estimated to yield $26 million in Medicare savings and $16 million in Medicaid savings. CMS has approved this measure, and HSCRC indicated that it expects to implement this change beginning in April 2023.

CRF Availability in Fiscal 2024

At least 30% of the annual CRF appropriation must be used to support Medicaid expenses, as required by statute. Historically, this requirement is often surpassed, and any shortfalls in anticipated revenue are accounted for in the Medicaid budget. A fiscal 2023 deficiency appropriation under MCPA provides $7 million in available CRF revenue, bringing total CRF spending under Medicaid to $75.0 million (39.7% of total CRF uses) in fiscal 2023. The fiscal 2024 allowance also meets the statutory requirement with 32.7% of total CRF uses, or $46.0 million, supporting Medicaid. However, this reflects a $29 million CRF reduction while leaving an anticipated ending fiscal 2024 fund balance of $19.2 million. **DLS recommends reducing $15.0 million in general funds in recognition of the available CRF revenue to support Medicaid costs in fiscal 2024.**

Provider Rate Increases

Compared to the fiscal 2023 working appropriation, MCPA's fiscal 2024 allowance increases by $214.7 million to account for provider rate increases. **Exhibit 11** lists rate increases by service/provider type budgeted under MCPA, excluding rate increases supported with federal funds authorized in the ARPA and rate increases budgeted outside of MCPA. The mandated 4% rate increases for certain providers defined in Chapters 10 and 11 of 2019 are fully funded in the fiscal 2024 allowance.

Exhibit 11
Medicaid and MCHP Provider Rate Changes and Rate Assumptions
Fiscal 2024
($ in Millions)

	Rate Change
Nursing Homes (Mandated 4%)	$89.5
Managed Care Organization Calendar 2023 (1.1%)	84.7
Inpatient and Outpatient Services (3.45%)	27.1
Pharmacy (3%)	13.3
HCBS Providers (Mandated 4%)	*
Total	**$214.7**

HCBS: Home- and Community-based Services
MCHP: Maryland Children's Health Program

*The fiscal 2024 allowance includes mandated 4% provider rate increases for HCBS providers, as required by Chapters 10 and 11 of 2019. However, these providers received a temporary 4% rate increase fully supported with federal funds authorized in the American Rescue Plan Act of 2021 that end after fiscal 2023, offsetting the mandated provider rate increase.

Source: Maryland Department of Health; Department of Budget and Management; Department of Legislative Services

Under MDH's Office of the Secretary, the fiscal 2024 budget plan provides $413.4 million in total funds to accelerate all mandated provider rate increases across BHA, the MDH Developmental Disabilities Administration (DDA), and Medicaid, contingent on the enactment of legislation accelerating the implementation of Maryland's minimum wage law. This funding is further discussed in the budget analysis for MDH – Administration – M00A01.

Temporary Rate Increases for Home- and Community-based Service Providers Funded with ARPA Federal Support

A provision in the ARPA provided significant federal funding for Home- and Community-based Services (HCBS) expansion efforts by authorizing a 10% enhanced federal match on qualifying HCBS expenses from April 1, 2021, through March 31, 2022. CMS issued guidance in May 2021, requiring that State fund savings resulting from the enhanced federal match be reinvested to enhance, expand, or strengthen HCBS under the Medicaid program by March 31, 2024. Long Term Services and Supports (LTSS) providers under Medicaid are estimated to receive $160.7 million in State fund reinvestment from this provision. Additional information about ARPA support for HCBS departmentwide can be found in the budget analysis for MDH – Overview – M00.

Particularly for Medicaid, language in the fiscal 2022 Budget Bill further specified the use of ARPA funding for HCBS by requiring that at least 75% of the enhanced federal matching funds be used on a one-time provider rate increase. The department met this requirement by announcing a 5.2% rate increase for Medicaid HCBS providers that took effect November 1, 2021. Although the language mentions a requirement for one-time rate increases, MDH indicated that the fiscal 2024 budget plan continues to fund the 5.2% rate increases beyond March 31, 2024, when ARPA reinvestment expires. MDH also chose to dedicate the remaining 25% ARPA HCBS reinvestment for Medicaid LTSS providers for rate increases as well.

Exhibit 12 shows the rate increases and timeframes supported with ARPA HCBS reinvestment in Medicaid that are distributed in addition to the mandated rate increases provided in Chapters 10 and 11. The 4% emergency rate increase for HCBS providers under Medicaid ends after fiscal 2023, and as a result, this reduction in spending offsets the mandated 4% provider rate increase for those providers that takes effect July 1, 2023.

Exhibit 12
Medicaid HCBS Provider Rate Increases Funded with ARPA Support
Fiscal 2021-2024

Medicaid Providers	Rate Increases	Timeframe
All HCBS Providers	5.2%	Effective November 1, 2021 – Support with ARPA reinvestment for 2.5 years, then ongoing.
Autism Waiver; Community Options Waiver; Medical Day Care Waiver; and Model Waiver Providers	4.0%	One year – emergency rate increase in fiscal 2023.

ARPA: American Rescue Plan Act of 2021
HCBS: Home- and Community-based Services

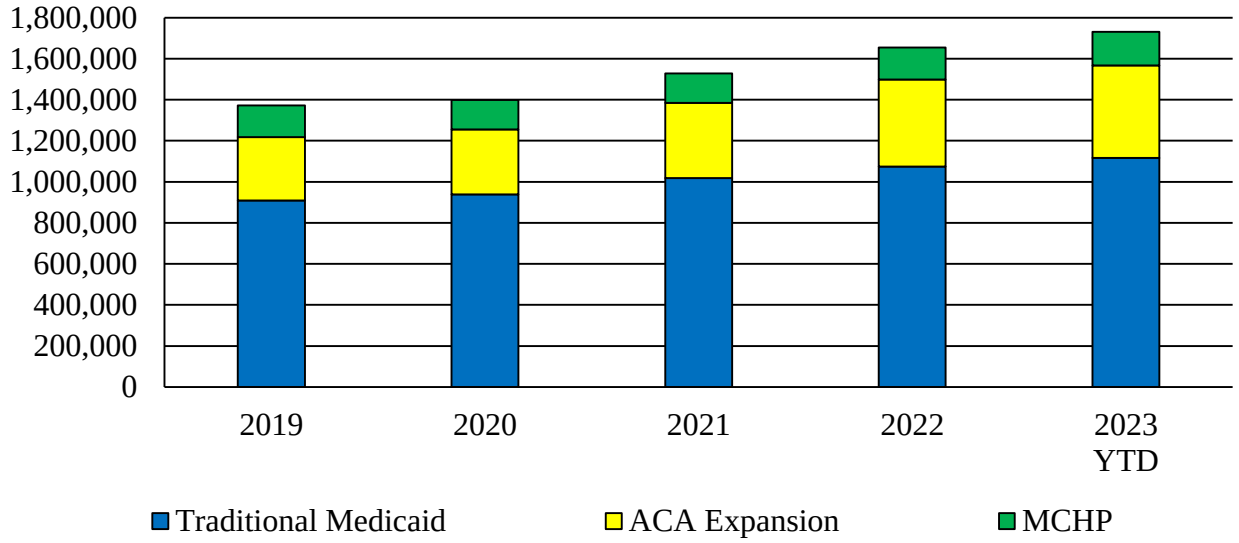
Source: Maryland Department of Health; Department of Legislative Services

COVID-19 PHE Enrollment Trends

The single largest driver of reduced spending in the fiscal 2024 allowance compared to fiscal 2023 spending is the budgetary impact of projected declines in enrollment and utilization. As a condition of receiving the COVID-19 enhanced FMAP, Maryland has been required to freeze Medicaid disenrollment (with limited exceptions) during the national COVID-19 PHE that was first declared on January 31, 2020. This led average monthly enrollment to grow by approximately 26.1%, or 358,530 Medicaid recipients per month on average, from fiscal 2019 to 2023 year to

date, as shown in **Exhibit 13**. The Consolidated Appropriations Act ends the continuous enrollment requirement on March 31, 2023.

Exhibit 13
Medicaid and MCHP Average Monthly Enrollment
Fiscal 2019-2023 Year to Date

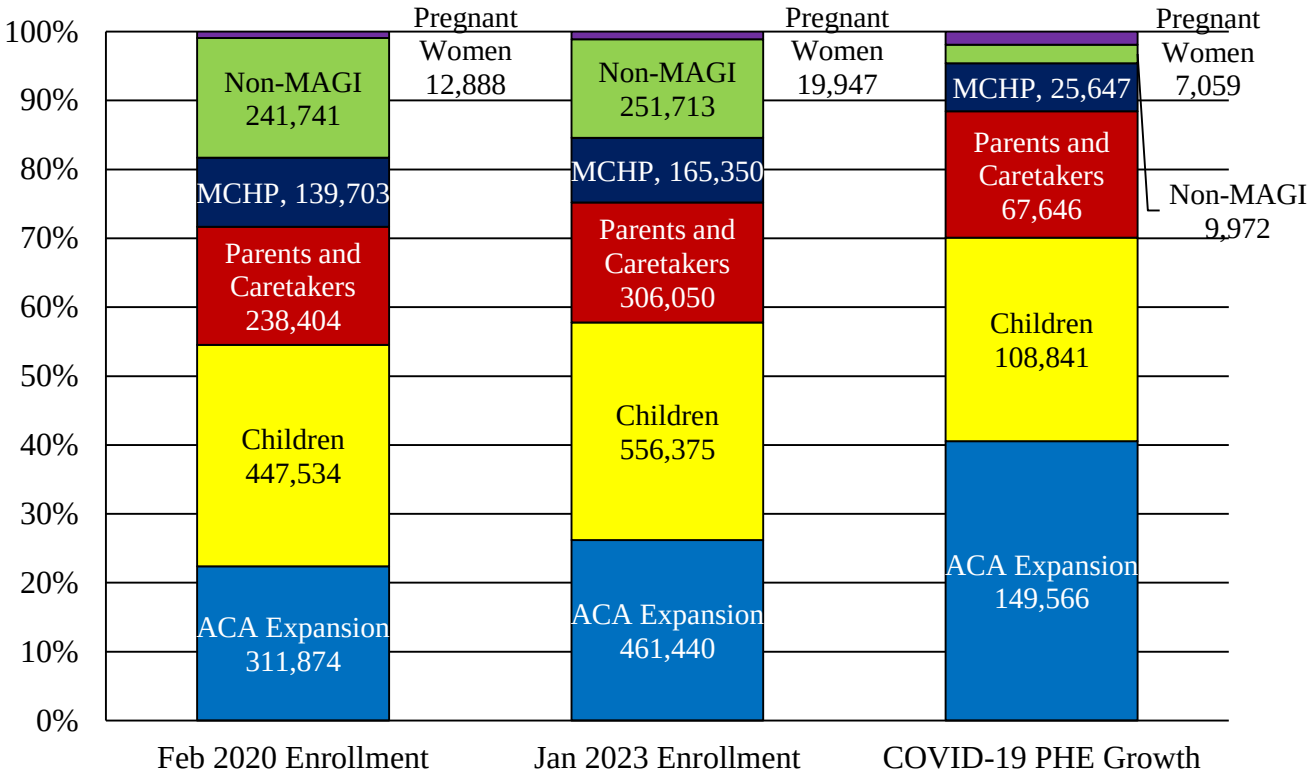


ACA: Affordable Care Act
MCHP: Maryland Children's Health Program
YTD: year to date

Source: Maryland Department of Health; Department of Budget and Management; Department of Legislative Services

When looking at enrollment trends during the COVID-19 PHE by eligibility category, certain groups have made up a larger share of pandemic growth compared to their overall share of Medicaid enrollment, as shown in **Exhibit 14**. This trend is especially true across Modified Adjusted Gross Income (MAGI) populations that are eligible for Medicaid solely based on income. Non-MAGI populations (more complex cases that qualify by meeting certain other requirements, such as having a disability) accounted for 17% of total Medicaid and MCHP enrollment in February 2020 but only 3% of the increase in enrollment from February 2020 to January 2023. This outcome is expected as the start of the COVID-19 PHE led to economic instability and significant job losses, causing more people to qualify in MAGI groups while eligibility for non-MAGI groups remained more consistent.

Exhibit 14
Medicaid and MCHP Enrollment by Eligibility Category
February 2020, January 2023, and COVID-19 PHE Growth



ACA: Patient Protection and Affordable Care Act
MAGI: Modified Adjusted Gross Income
MCHP: Maryland Children's Health Program
PHE: public health emergency

Source: Maryland Department of Health; Department of Budget and Management; Department of Legislative Services

The COVID-19 PHE also had varied enrollment impacts across the MAGI eligibility categories, with the ACA expansion group accounting for the largest share of COVID-19 PHE growth at 41% compared to its 22% share of total enrollment in February 2020. The enrollment mix of those who joined Medicaid and stayed on throughout the continuous enrollment period has a significant impact on the State funds needed to cover the increased enrollment because some groups receive a higher federal match than other groups. For example, the ACA expansion group receiving 90% federal matching funds and MCHP enrollees receiving 65% federal matching funds. Parents and caretakers and children require more State fund support due to the 50% FMAP for

those groups. Trends in the eligibility groups that saw higher enrollment growth during the pandemic also informed DLS enrollment projections for which groups may be disenrolled at a faster rate, once MDH resumes disenrolling ineligible individuals through its redetermination process.

Enrollment Redetermination Process

At the time that the fiscal 2023 budget was enacted, the COVID-19 PHE was set to expire before fiscal 2023, and Medicaid enrollment was expected to decline swiftly after the continuous enrollment requirement ended. Since then, the Secretary of the U.S. Department of Health and Human Services extended the COVID-19 national PHE multiple times, thereby pushing the redetermination timeline out until the Consolidated Appropriations Act eventually set a specific end date of March 31, 2023, for the freeze on disenrollment, regardless of when the PHE ends.

On January 5, 2023, CMS issued guidance to state Medicaid programs on planning a return to normal operations and eligibility redeterminations beginning April 1, 2023. This guidance reiterated the established policy that states may use up to 12 months to initiate eligibility renewals and may use up to 14 months to complete eligibility renewals. One of the reasons for this decision was to avoid overloading any one month with more eligibility redeterminations than a Medicaid office could feasibly manage. This first year of redeterminations will effectively create a new annual redetermination schedule moving forward. States, however, can still determine their own redetermination timelines, so there will likely be a range in results across states that take an aggressive approach to disenrollment versus states that space out the process.

MDH plans to use the full 14 months following April 1, 2023, to complete its redetermination process. This means that the first round of renewals that may end in disenrollment will begin April 1, but individuals will not lose coverage until June 1 after their renewal materials are reviewed and outreach and notice has been sent about the upcoming disenrollment.

In the first six months, however, MDH plans to expedite redeterminations for certain individuals who have reported information making most of them ineligible for continued coverage. The department indicated on February 17, 2023, that this group totaled approximately 186,000 individuals. MDH previously reported estimates of approximately 55,000 individuals likely to be ineligible and disenrolled early, so the more recent 186,000 number is a substantial increase over prior estimates.

The department described certain factors that make this group more likely to be ineligible, such as reporting an increase in household income above the maximum threshold or an individual not meeting technical eligibility after aging out of Medicaid and into Medicare coverage. Although the eligibility category breakdown for this group was not available at the time this analysis was written, certain enrollment trends, such as larger shares of ACA expansion joining Medicaid throughout the PHE, were applied to estimate the impact this group's widespread disenrollment would have across enrollment categories and on the State budget. MDH plans to conduct renewals for about the same share of the 186,000 individuals per month beginning in May 2023, though the department will prioritize individuals that appear ineligible due to income first so that they all

complete the redetermination process by October 2023 and individuals with more technical reasons for possibly not being eligible will be redetermined through November 2023.

Language in the fiscal 2023 Budget Bill restricted funds pending quarterly reports with updates on the COVID-19 PHE and eligibility redetermination process. MDH submitted the first report on January 9, 2023, with information as of December 1, 2022. In this report, MDH described partnering with stakeholders, including MCOs, the Maryland Health Benefit Exchange, and the Department of Human Services, to prepare outreach efforts and develop consistent messaging for the unwinding and termination of the COVID-19 PHE. The department specified that outreach efforts would be data driven and would focus on Medicaid participants and health care providers. Once states start terminating coverage again, there is some concern that State agencies may disenroll individuals who are eligible for Medicaid and had some change in their mailing address or some other difficulty confirming their eligibility status.

DLS recommends the release of $250,000 in general funds restricted in fiscal 2023 pending the submission of the first quarterly report and will process a letter to this effect if no objections are raised by the subcommittees. DLS also recommends that the committees add language restricting fiscal 2024 funds for the purpose of administration until MDH submits continued quarterly reports with data and status updates related to the redetermination process.

Fiscal 2023 and 2024 Projected Enrollment and General Fund Adequacy

Exhibit 15 compares the revised enrollment figures assumed in the fiscal 2023 budget and fiscal 2024 allowance to DLS' fiscal 2023 and 2024 enrollment forecast. As a result of the federal government extending the COVID-19 PHE multiple times, Medicaid's fiscal 2023 legislative appropriation was based on much lower enrollment than is now anticipated in both models. A proposed fiscal 2023 deficiency provides a net increase of $685.5 million to the Medicaid budget and $35.0 million to the MCHP budget to cover added costs from the revised estimated enrollment increase. This action also accounts for changes in utilization and provider rate assumptions. Compared to the adjusted fiscal 2023 working appropriation, the fiscal 2024 allowance reflects a net reduction of $924.1 million in Medicaid spending resulting from the estimated 9.7% overall enrollment and utilization decline.

Exhibit 15
DLS and DBM Enrollment Forecasts
Fiscal 2023-2024

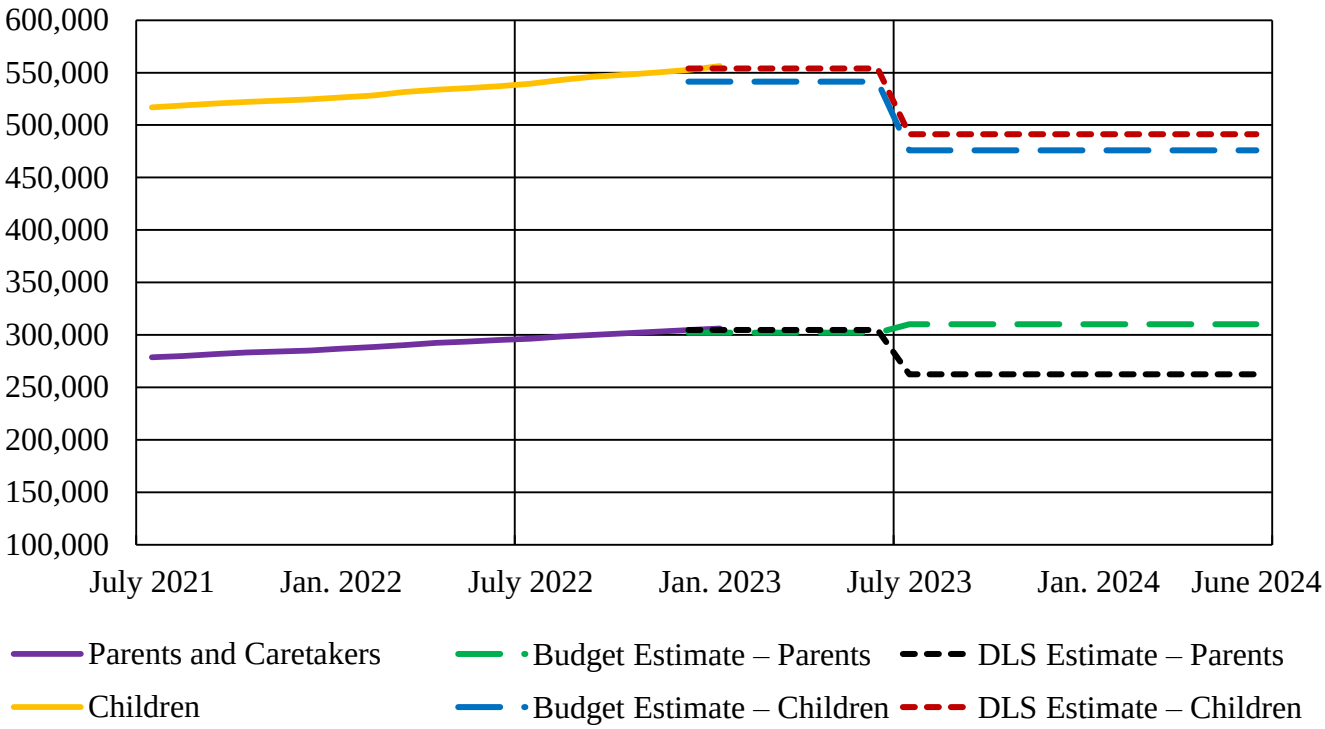
	2023		2024		% Change 2023-2024	
	Adjusted Working	DLS Estimate	Allowance	DLS Estimate	Adjusted Working to Allowance	DLS 2023 Estimate to DLS 2024 Estimate
Traditional Medicaid	1,114,689	1,128,575	1,062,775	1,026,078	-4.7%	-9.1%
ACA Expansion	449,957	458,350	350,371	358,349	-22.1%	-21.8%
MCHP	162,568	164,740	146,877	154,056	-9.7%	-6.5%
Total	**1,727,214**	**1,751,665**	**1,560,023**	**1,538,483**	**-9.7%**	**-12.2%**

ACA: Affordable Care Act
DBM: Department of Budget and Management
DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

Source: Department of Budget and Management; Department of Legislative Services

Despite the DLS fiscal 2023 estimated enrollment including 24,451 additional enrollees per month overall, the difference in the assumed enrollment mix lessens the estimated funds needed to cover these individuals. In fiscal 2024, DLS estimates a lower overall enrollment (21,540 fewer enrollees). The largest difference in the enrollment mix between the two models is enrollment attributed to children versus adults in fiscal 2024. As shown in **Exhibit 16**, the DLS estimate reflects slightly more children per month (15,000 more) and substantially fewer parents and caretakers participating in the Medicaid program (47,000 fewer) in fiscal 2024 compared to the budget estimates. The caseload used for budget development anticipates that parents and caretakers will remain at the elevated enrollment level in fiscal 2024, even though disenrollment resumes in June 2023 and enrollment among children is projected to decrease.

Exhibit 16
Medicaid Enrollment Among Children, Parents, and Caretakers
July 2021 to June 2024 Estimated



DLS: Department of Legislative Services

Source: Maryland Department of Health; Department of Budget and Management; Department of Legislative Services

As shown in **Exhibit 17**, projected fiscal 2024 enrollment mix differences translate to an estimated $200 million in reduced total fund spending and $95 million in reduced general fund spending under Medicaid and MCHP in the DLS forecast compared to the fiscal 2024 allowance. The significant difference in anticipated enrollment among parents and caretakers especially drives this total cost difference. The DLS forecast assumes greater enrollment declines in groups that would have a greater impact on general fund need, such as parents and caretakers who receive a 50% FMAP. The DLS fiscal 2024 estimate tends to show slower declines among children in both Medicaid and MCHP compared to the estimates used for budget development, but these groups do not outweigh the cost savings of greater enrollment decline in the other groups.

Exhibit 17
Budget vs. DLS Estimated Total Medicaid Cost Differences
Fiscal 2024

	Budgeted Annual Cost Per Person		DLS Budget Enrollment	Estimated Cost Difference	
	Total Funds	General Funds	Difference	Total Fund	General Fund
Parents and Caretakers	$6,067	$2,350	-47,713	-$289,487,441	-$112,142,984
Disabled Adults	18,380	8,760	-1,544	-28,383,219	-13,527,986
Undocumented/ Unqualified Immigrants	46,975	23,488	-408	-19,161,992	-9,580,996
Elderly	27,405	10,725	-482	-13,218,641	-5,173,179
Disabled Children	15,199	6,592	-604	-9,178,490	-3,981,069
Other Adults	1,375	659	-2,502	-3,441,461	-1,647,685
Former Foster Care Youth	7,055	3,528	-3	-17,839	-8,919
MCHP	2,645	898	7,179	18,990,427	6,447,074
Pregnant Women	18,361	9,181	1,190	21,856,754	10,928,377
Medicaid Children	3,194	1,597	15,369	49,086,228	24,543,114
ACA Expansion	7,764	776	7,978	61,940,515	6,194,052
Total	**$154,422**	**$68,554**	**-21,540**	**-$211,015,158**	**-$97,950,203**

ACA: Patient Protection and Affordable Care Act
DLS: Department of Legislative Services
MCHP: Maryland Children's Health Program

Source: Maryland Department of Health; Department of Budget and Management; Department of Legislative Services

Overall, fiscal 2023 costs increase in both models due to increased enrollment and utilization compared to the legislative appropriation. Although DLS' enrollment estimate is slightly higher, the savings related to the enrollment mix leads to the fiscal 2023 working appropriation being adequate to cover estimated costs in the DLS forecast.

In the fiscal 2024 models, total enrollment shows significant declines as that fiscal year accounts for the majority of the initial 14-month redetermination cycle. Based on MDH's new estimate of 186,000 individuals that are likely ineligible and will be prioritized for disenrollment in the first six months following redeterminations resuming, the DLS model assumes an overall higher reduction of 12.2% in total enrollment between fiscal 2023 and 2024 compared to the

Department of Budget and Management model. However, the anticipated differences in the enrollment mix, specifically the parents and caretakers group, create much larger differences in estimated total cost and general fund cost between the two forecasts.

DLS recommends reducing the Medicaid budget by $115 million in total funds ($70 million in general funds) to account for updated enrollment projections and anticipated savings from reduced hospital costs in fiscal 2024.

Future Enrollment Considerations

Aside from the provisions related to the COVID-19 PHE unwinding, the Consolidated Appropriations Act further impacts Medicaid and MCHP by requiring that all states provide continuous eligibility to children enrolled in Medicaid or MCHP for 12 months, beginning January 1, 2024. To the extent that children lost Medicaid or MCHP coverage mid-year (prior to the freeze on disenrollment during the COVID-19 PHE), those children would now keep their benefits up to one year after they enrolled. Therefore, this policy change is likely to increase monthly Medicaid and MCHP enrollment slightly. Although some states already offered 12-month continuous eligibility for children, above federal eligibility requirements, Maryland did not provide for this. MDH indicated that it will target earlier implementation in August 2023. The policy will also apply prospectively, so until this continuous eligibility provision is established in Maryland, children enrolling in Medicaid or MCHP would still be disenrolled mid-year.

Personnel Data

	FY 22 Actual	FY 23 Working	FY 24 Allowance	FY 23-24 Change
Regular Positions	618.00	608.00	619.00	11.00
Contractual FTEs	83.05	114.83	170.80	55.97
Total Personnel	**701.05**	**722.83**	**789.80**	**66.97**

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	41.40	6.81%
Positions and Percentage Vacant as of 12/31/22	80.60	13.26%
Vacancies Above Turnover	39.2	

- The fiscal 2024 allowance includes 11 new positions under MCPA to convert existing contractual full-time equivalents (FTE) to regular positions. Of these positions:

- 6 provide administrative and fiscal services for the Office of Finance;

- 3 are health policy roles budgeted within the Office of Benefits Management and Provider Services; and

- 2 are administrative roles within the Office of Eligibility Services.

- Despite MCPA receiving 11 contractual conversions, the fiscal 2024 contractual staffing level increases by a net 56 FTEs compared to the fiscal 2023 working appropriation. More than half of these FTEs (approximately 28 FTEs) are budgeted under the Office of Benefits Management and Provider Services for various health policy analysis and administrative duties. The Office of Enterprise Technology also receives about 20 FTEs in fiscal 2024 for administrative and information technology (IT) support needs in the department.

It is not clear why the duties and roles assigned to the new contractual FTEs would be short term in nature and would be best served by contractual personnel, rather than regular personnel support, especially considering some of the new contractual roles have similar descriptions as the contractual conversions included in the fiscal 2024 allowance. Furthermore, ongoing Medicaid coverage and program expansion discussed in Issue 2 is likely to cause long-term workload increases.

MDH should explain why the staffing support and assigned duties provided by the net 55.97 contractual FTEs are adequately served by contractual personnel rather than new regular positions. This discussion should also clarify if the positions are performing duties that are short term in nature or, alternatively, if there is an ongoing need for this staffing support. The department should also discuss whether long-term vacant positions could be repurposed to fill some of these roles.

- As of December 31, 2022, MCPA reported 80.6 vacancies, which is significantly higher than the 41.4 vacant positions needed to meet budgeted turnover. More than 30% of the vacant positions (24.6 positions) have been vacant for more than a year.

Issues

1. OLA Fiscal 2022 Statewide Closeout Audit Finding

Each year, OLA conducts a review of the State's preceding fiscal year budget closeout transactions to determine whether transactions were properly supported and if there were any significant liabilities that existed at the end of the fiscal year. A finding included in OLA's *Statewide Review of Budget Closeout Transactions for Fiscal Year 2022* related to MDH's process for accruing and tracking federal fund revenue receivables.

OLA selected 16 journal entries tracked through MDH's automated tracking process that totaled $3.5 billion in federal fund revenue accruals and found that MDH could not support the propriety of the accrued federal fund revenue as of June 30, 2022. Furthermore, the department did not identify and recover $862.5 million in federal fund revenue until OLA informed MDH staff of the unrecovered funds in August 2022, which led MDH to subsequently request and recover the federal funds in September 2022. OLA indicates that this occurred because MDH administers an automated process for tracking accrued federal fund revenue that did not collect enough detail or verify that accruals carried forward into the next fiscal year would be recoverable.

MDH should discuss the steps it is taking to resolve this significant audit finding. Additionally, the department should explain how it is changing internal accrual tracking processes to collect all necessary support information and verifying the source and timing of accrued federal fund revenue recovery moving forward, including the timeframe for any procedural changes to take effect.

2. Medicaid Coverage Expands Significantly through Recent Legislation

Legislation from the 2022 session expanded Medicaid coverage and altered program requirements, with select changes described in the following.

- ***Adult Dental Coverage Expansion:*** Prior to the enactment of Chapters 302 and 303, Medicaid and MCHP only provided comprehensive dental benefits to children and certain adults, including income-eligible pregnant women, certain former foster care adolescents, and adults enrolled in the Rare and Expensive Case Management program. All nine MCOs operating in Maryland voluntarily covered limited adult dental services for their members as an add-on benefit but did not receive reimbursement from MDH for these services. Individuals ages 21 to 64 who were dually eligible for Medicaid and Medicare could also receive dental benefits through a statewide pilot program that took effect June 1, 2019.

  Chapters 302 and 303 required Medicaid to cover diagnostic, preventive, restorative, and periodontal dental services for adults with household incomes up to 133% of the FPL beginning January 1, 2023. The fiscal 2023 working appropriation includes $77.7 million in total funds to expand dental coverage and the fiscal 2024 allowance annualizes these

costs, providing $154.0 million in total funds. At least initially, MDH is rolling out the new adult dental benefit on a FFS basis, similarly to how dental benefits were covered for other eligibility groups prior to this expansion.

MDH should provide an update on implementation of the adult dental coverage expansion, including any plans to change the financing structure for dental services from FFS to paying through capitated rates.

- ***Healthy Babies Equity Act:*** Chapter 28 of 2022 requires Medicaid to provide comprehensive medical care and other health care services to noncitizen pregnant women who would be eligible for Medicaid, but for their immigration status, and codifies the requirement that Medicaid cover their children up to the age of one. MDH is working with CMS to meet all federal requirements to expand coverage to this new eligibility group, with implementation expected to start in July 2023.

- ***Community Options Waiver:*** Chapter 738 of 2022 required the Community Options Waiver, which provides HCBS to individuals not otherwise qualified for Medicaid to avoid institutionalization in nursing facilities or other health facilities, to include a cap on participation and a plan for waiver participation of at least 7,500 individuals. The department was required to apply to CMS to increase the waiver cap by October 31, 2022.

  MDH must also send waiver applications to at least 600 individuals on the waitlist each month starting October 1, 2022, doubling prior-year registry outreach efforts. MDH indicated that necessary IT changes had not been completed as of October 1, 2022, preventing the department from meeting the expanded registry outreach requirement on time. As of February 2, 2023, MDH expected to complete the IT upgrades and begin its expanded outreach activities by June 2023. Further discussion of the Community Options Waiver registry and other HCBS waitlists can be found in the budget analysis for MDH – Overview – M00.

  Considering the recent program changes and expansion efforts under the Community Options Waiver and CFC program, which consolidates multiple long-term care services, DLS recommends adopting narrative requesting two reports on CFC program and Community Options Waiver financial and registry data.

Emergency Medical Services (EMS) Transport: Chapter 668 of 2022 expanded Medicaid reimbursement to EMS transporters to include reimbursement for medical services provided in response to a 9-1-1 call in situations when the Medicaid recipient is not transported to a facility and for mobile integrated health services. MDH submitted proposed regulations to implement these changes with an effective date of January 1, 2023. The reimbursement rate to transport a Medicaid recipient to a facility in response to a 9-1-1 call or provide medical services while transporting the Medicaid recipient must also increase to at least $150, beginning in fiscal 2023.

- ***Community Violence Programs:*** Chapters 504 and 505 of 2022 require Medicaid, subject to federal approval, to provide community violence prevention services beginning July 1, 2023. These services include peer support and counseling, mentorship, conflict mediation, and crisis intervention, among other evidence-based, trauma-informed services.

- ***Coverage of Abortion Care Services:*** Chapter 56 of 2022 requires Medicaid to cover abortion care services without restrictions that are inconsistent with specified protected rights under Title 20, Subtitle 2 of the Health-General Article. Medicaid must also provide information to enrollees about abortion care coverage using the terminology "abortion care" to describe coverage.

  Annual language in the budget bill, attached to Medicaid since 1979 and MCHP since 1999, authorized the use of State funds to pay for abortions under specific circumstances. The General Assembly amended this language in the fiscal 2023 budget to comply with provisions in Chapter 56, such as allowing qualified providers, in addition to physicians or surgeons, to certify the necessity of an abortion procedure and perform the procedure for eligible Medicaid enrollees. The fiscal 2024 Budget Bill as introduced includes the annual language without the amendments that were made in fiscal 2023, returning the language back to fiscal 2022 and prior phrasing. More information about abortion services funded under Medicaid can be found in Update 1 of this analysis.

Operating Budget Recommended Actions

1. Add the following language to the general fund appropriation:

, provided that $1,000,000 of this appropriation made for the purpose of administration in the Office of the Deputy Secretary for Health Care Financing may not be expended until the Maryland Department of Health submits quarterly reports on the Medicaid and Maryland Children's Health Program eligibility redetermination process that will resume on April 1, 2023. Each report shall include the following data on a monthly basis and divided by eligibility category:

(1) the number of eligibility renewals initiated;

(2) the number of new individuals enrolled;

(3) the number of individuals enrolled who received medical assistance and were subsequently disenrolled any time in the six months prior to reenrolling;

(4) the number of individuals disenrolled along with the number disenrolled by reason for disenrollment, identifying disenrollments due to failure to apply for recertification, missing information/verifications, overscaled income, aging out of a Medicaid eligibility category, and other common reasons for disenrollment;

(5) call center volume, average wait times, and any other data related to call center activities that are required to be submitted to the Center for Medicare and Medicaid Services; and

(6) measures of application processing times and total numbers of applications processed for Modified Adjusted Gross Income eligibility groups and non-Modified Adjusted Gross Income eligibility groups shown separately.

The first report shall be submitted by July 15, 2023, and the other reports shall be submitted quarterly thereafter. The funds may be released in $250,000 increments following the submission of each quarterly report. The budget committees shall have 45 days from the date of the receipt of each report to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the reports are not submitted to the budget committees.

Explanation: This language restricts funds budgeted for administrative purposes until the Maryland Department of Health (MDH) submits quarterly reports with data and status updates related to the Medicaid and Maryland Children's Health Program eligibility redetermination process.

Information Request	Author	Due Date
Quarterly reports on Medicaid and Maryland Children's Health Program eligibility redetermination	MDH	July 15, 2023 October 15, 2023 January 15, 2024 April 15, 2024

2. Add the following language to the general fund appropriation:

Further provided that $250,000 of this appropriation made for the purpose of administration in the Office of the Deputy Secretary for Health Care Financing may not be expended until the Maryland Department of Health (MDH) Medical Care Programs Administration submits a report, in consultation with the MDH Behavioral Health Administration and MDH Developmental Disabilities Administration, on current Medicaid rates, rate enhancements, and rate-setting studies. The report shall include the following information for each provider type:

(1) a timeline for when the current rate structure and rates were determined;

(2) the method for determining and establishing the current rate structure and rates, including whether a rate-setting study was conducted (and if not, the reason for a rate-setting study not being conducted), and a discussion of how actual provider expenditures were taken into account in setting rates;

(3) a summary of recent rate increases and enhancements;

(4) the status of any ongoing rate-setting studies and plans for future rate-setting studies; and

(5) a description of any federal requirements affecting the rate structure, such as whether rates must be actuarially sound, must cover certain costs, or cannot differ across certain service types, geographic locations, or provider types.

The report shall be submitted by October 1, 2023, and the budget committees shall have 45 days from the date of the receipt of the report to review and comment. Funds restricted pending the receipt of a report may not be transferred by budget amendment or otherwise to any other purpose and shall revert to the General Fund if the report is not submitted to the budget committees.

Explanation: This language restricts funds budgeted for administrative purposes until MDH submits a report on current Medicaid rate structures and rate-setting studies. The report shall provide information on rates for all provider types funded through the Medical Care Programs Administration (Medicaid), Behavioral Health Administration (BHA), and Developmental Disabilities Administration (DDA) separately, including disaggregating provider types within each administration. Language in the fiscal 2023 Budget Bill also

restricted funds pending the submission of a report on Medicaid rates and rate-setting studies, but MDH had not provided the requested report as of February 20, 2023.

Information Request	Author	Due Date
Report on Medicaid rates and rate-setting studies	Medicaid BHA DDA	October 1, 2023

3. Add the following language:

Provided that all appropriations provided for program M00Q01.03 Medical Care Provider Reimbursements are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that funds may be transferred to program M00Q01.07 Maryland Children's Health Program. Funds not expended or transferred shall be reverted or canceled.

Explanation: This budget language restricts funding for Medical Care Provider Reimbursements to that purpose only and prevents budgetary transfers to any program except M00Q01.07 Maryland Children's Health Program.

		Amount Change	
4.	Reduce general funds within the Medicaid program and authorize a budget amendment to be processed to replace these funds with special funds in recognition of available Cigarette Restitution Fund support. This reduction in Cigarette Restitution Fund balance would maintain an estimated fiscal 2024 closing balance of $4.2 million.	-$ 15,000,000	GF
5.	Reduce funding for Medicaid reimbursements based on reduced enrollment and hospital services spending expectations.	-$ 70,000,000 -$ 45,000,000	GF FF

6. Adopt the following narrative:

Community First Choice (CFC) Program and Home- and Community-based Options (Community Options) Waiver Financial and Registry Data: Recent efforts to expand home- and community-based services have led to significant increases in CFC program expenditures, including spending under the Community Options waiver. The committees request that the Maryland Department of Health (MDH) submit two reports on CFC program spending. The reports should include monthly enrollment, utilization, and cost data that aligns with actual budget expenditures under the CFC program, and the initial

report should include data that reconciles to actual spending in fiscal 2022 and 2023. Each report should also provide:

- the number of Community Options waiver slots filled in fiscal 2023 and fiscal 2024 year to date;

- the number of Community Options waiver applications sent to individuals on the registry each month and the results of that outreach (including the number of applications returned and processed);

- updates on changes to registry operations to improve efficiency in taking individuals off of the registry and efforts to determine financial and medical eligibility for individuals while they remain on the registry;

- the number of individuals on the Community Options waiver registry; and

- an update on any activities or efforts to implement the plan to reduce the Community Options waiver registry by 50% submitted to the General Assembly in February 2023.

Information Request	**Author**	**Due Date**
Report on CFC program and Community Options waiver financial and registry data	MDH	August 1, 2023 December 1, 2023

7. Adopt the following narrative:

Rate Adjustments for Dental Services under the Medical Assistance (Medicaid) Program: The committees are interested in the Maryland Department of Health's (MDH) implementation of a reimbursement rate increase for dental services covered under Medicaid in fiscal 2023. The committees request that MDH submit a report by December 1, 2023, that includes:

- the percentage increase in Medicaid reimbursement rates for dental services overall and by service type budgeted in fiscal 2023 over fiscal 2022 dental rates and fiscal 2024 over fiscal 2023 dental rates;

- a comparison of fiscal 2024 Medicaid dental rates and commercial insurance rates for dental services in Maryland;

- a comparison of fiscal 2023 and 2024 rate increases for Medicaid dental services and recent rate increases for other Medicaid medical services; and

- additional adjustments to Medicaid dental rates that would need to be considered as part of the implementation of a permanent adult dental services benefit under the Medicaid program.

This report was also requested in the 2022 Joint Chairmen's Report, but as of February 20, 2023, MDH had not submitted a report.

Information Request	Author	Due Date
Report on reimbursement rates for dental services under Medicaid	MDH	December 1, 2023

8. Adopt the following narrative:

Employed Individuals with Disabilities (EID) Program Eligibility Requirements: The EID Program, also known as the Medicaid Buy-in, extends medical assistance to working Marylanders with disabilities. Individuals ages 18 to 64 are eligible if they meet certain work and income requirements, with the income of the individual's spouse included in eligibility determination. The fiscal 2023 budget included $4.6 million to expand EID Program eligibility by removing the current income threshold of 300% of federal poverty guidelines and allowing both the income of an individual and individual's spouse to be disregarded during the eligibility determination process. Considering the eligibility expansion, the committees request that the Maryland Department of Health (MDH) submit a report on the EID Program including:

- the actual EID Program enrollment in fiscal 2021, 2022, 2023, and 2024 year to date, noting the number of participants enrolling and remaining enrolled in the program due to recent eligibility expansion and the number of participants by age grouping including 18 to 59 and 60 and older;

- the actual number of EID Program participants who were disenrolled and applicants who were denied due to turning 65 years old, not meeting maximum age requirements, surpassing the income eligibility threshold, and surpassing the asset threshold, reported separately by reason and by month in fiscal 2022, 2023, and 2024 year to date;

- the actual number of EID Program participants that reported getting married or otherwise updated their income for eligibility determination to include their spouse's income, reported separately by month in fiscal 2022, 2023, and 2024 year to date;

- the projected EID Program enrollment in fiscal 2024 for individuals ages 65 and older and ages 16 to 18, if program eligibility were extended to these groups;

- the actual EID Program expenditures in fiscal 2022, 2023, and 2024 year to date, with expenditures for eligibility expansion labeled separately;

- the actual EID Program expenditures in fiscal 2023 and projected EID Program expenditures in fiscal 2024, with expenditures for eligibility expansion labeled separately in both years; and

- a timeline and description of how EID Program eligibility was expanded in fiscal 2022 and 2023.

This report was also requested in the 2022 Joint Chairmen's Report, but as of February 20, 2023, MDH had not submitted a report.

Information Request	**Author**	**Due Date**
Report on EID Program eligibility requirements	MDH	January 15, 2024

9. Add the following language:

Provided that all appropriations provided for program M00Q01.07 Maryland Children's Health Program are to be used only for the purposes herein appropriated, and there shall be no budgetary transfer to any other program or purpose except that funds may be transferred to program M00Q01.03 Medical Care Provider Reimbursements. Funds not expended or transferred shall be reverted or canceled.

Explanation: This budget language restricts funding for the Maryland Children's Health Program to that purpose only and prevents budgetary transfers to any program except M00Q01.03 Medical Care Provider Reimbursements.

Total Net Change	**-$ 130,000,000**
Total General Fund Net Change	**-$ 85,000,000**
Total Federal Fund Net Change	**-$ 45,000,000**

Updates

1. Medicaid Expenditures on Abortion

Language attached to the Medicaid budget from fiscal 1979 to 2022 authorized the use of State funds to pay for abortions under specific circumstances. Specifically, a physician or surgeon must have certified that, based on his or her professional opinion, the procedure is necessary. Similar language has been attached to the appropriation for MCHP since its advent in fiscal 1999 through 2022.

The General Assembly amended the language regarding abortion services funded under Medicaid and MCHP in the fiscal 2023 Budget Bill to refer to any qualified provider of abortion services, as defined in Section 20-103 of the Health – General Article, and for the restrictive language to remain in effect for the first six months of fiscal 2023, contingent on enactment of Chapter 56 (the Abortion Care Access Act). Women eligible for Medicaid solely due to a pregnancy do not currently qualify for a State-funded abortion. **Exhibit 18** provides a summary of the number and cost of abortions by service provider in fiscal 2020 through 2022.

Exhibit 18
Abortion Funding under Medicaid
Fiscal 2020-2022

	Performed under 2020 State and Federal Budget Language	Performed under 2021 State and Federal Budget Language	Performed under 2022 State and Federal Budget Language
Abortions	9,909	10,997	11,567
Total Cost ($ in Millions)	**$6.6**	**$7.2**	**$7.6**
Average Payment Per Abortion	$663	$652	$659
Abortions in Clinics	7,572	8,289	8,981
Average Payment	$467	$465	$458
Abortions in Physicians' Offices	1,915	2,353	2,101
Average Payment	$989	$940	$954
Hospital Abortions – Outpatient	*	355	*
Average Payment	$2,691	$3,107	$3,062

	Performed under 2020 State and Federal Budget Language	Performed under 2021 State and Federal Budget Language	Performed under 2022 State and Federal Budget Language
Hospital Abortions – Inpatient	*	0	*
Average Payment	$10,931	$0	$19,968
Abortions Eligible for Joint Federal/State	0	0	0

*Indicates a dataset of less than 10 cases.

Note: Data for fiscal 2020 and 2021 includes all Medicaid-funded abortions performed during the fiscal year, while data for fiscal 2022 includes all abortions for which a Medicaid claim was filed through November 2022. Providers have up to 12 months after the date of service to submit fee-for-service claims; therefore, Medicaid may receive additional claims for abortions performed during fiscal 2022. For example, in fiscal 2022, 834 additional claims from fiscal 2021 were paid after November 2021. This explains differences in the fiscal 2021 data reported in this analysis compared to prior Medicaid budget analyses.

Source: Maryland Department of Health

Exhibit 19 indicates the reasons abortions were performed in fiscal 2022, according to the restrictions in the federal budget and State budget bill. Beginning on January 1, 2023, the amended budget language regarding abortion services authorized Medicaid and MCHP funds to cover abortion care services with restrictions that are consistent with Title 20, Subtitle 2 of the Health – General Article, also contingent on Chapter 56. The fiscal 2024 allowance as introduced includes language attached to the Medicaid and MCHP budgets that returns to the phrasing included in fiscal 1979 to 2022 budget bills, authorizing the use of State funds to pay for abortions under specific circumstances.

Exhibit 19
Abortion Services by Reason
Fiscal 2022

I. Abortion Services Eligible for Federal Financial Participation
(Based on restrictions contained in the federal budget.)

Reason		Number
1.	Life of the woman endangered.	0
	Total Received	**0**

II. Abortion Services Eligible for State-only Funding
(Based on restrictions contained in the fiscal 2021 State budget.)

1.	Likely to result in the death of the woman.	0
2.	Substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.	453
3.	Medical evidence that continuation of the pregnancy is creating a serious effect on the woman's mental health and, if carried to term, there is a substantial risk of a serious or long-lasting effect on the woman's future mental health.	11,091
4.	Within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.	*
5.	Victim of rape, sexual offense, or incest.	*
Total Fiscal 2022 Claims Received Through November 2022		**11,567**

*Indicates a dataset of less than 10 cases.

Source: Maryland Department of Health

2. Medicaid Administrative Claiming for School-based Health Services

In July 2018, Medicaid hired a consulting firm to review its existing business process and organizational structure and to make recommendations for improvement, which ultimately included recommendations concerning how local education agencies claim administrative costs through Medicaid for certain school-based services. Schools can receive Medicaid funding in three ways: through school-based health centers that act as providers; through services, such as speech therapy and counseling, provided as part of a student's Individualized Education Plan; and school-based administrative services that support the provision of Medicaid services to children in schools and activities related to outreach and enrollment.

A Maryland State Department of Education response to committee narrative in the 2019 JCR on maximizing Medicaid claims for school-based health services found that Maryland would need to take the following steps to initiate an administrative claiming program for school-based services:

- conduct a program needs assessment based on updated federal guidance;
- develop an allocation methodology and time study procedure for school districts to calculate reimbursable administrative activities based on revised federal guidelines;
- obtain CMS approval;
- implement the program; and
- maintain ongoing oversight and program management functions.

In a status report on this same subject submitted on September 15, 2022, in response to language in the fiscal 2023 Budget Bill, MDH reiterated that Medicaid did not employ an administrative claiming program for school-based services at that time. The response highlighted that the U.S. Department of Health and Human Services Office of the Inspector General found vulnerabilities in school-based administrative claiming methodologies and deficiencies in time-study methodologies at both the State and federal levels, leading to a significant volume of improper payments. Federal guidance for states on school-based administrative claiming had not been updated since calendar 2003. Therefore, MDH would not assess the feasibility or timeline for completing the steps outlined above to implement an administrative claiming program in the future, until CMS issues updated federal guidance.

Appendix 1
2022 *Joint Chairmen's Report* Responses from Agency

The 2022 JCR requested that MCPA prepare seven reports. Electronic copies of the full JCR responses can be found on the DLS Library website.

- ***Quarterly Reports with Data and Status Updates Related to Redetermination:*** MDH submitted the first of four requested quarterly reports on January 9, 2023, but had not provided the second report due on February 1, 2023, as of the writing of this report. Additional information regarding Medicaid's redetermination process can be found in the Fiscal 2024 allowance section of this analysis.

- ***Report on Medicaid Rates and Rate-setting Studies:*** As of February 18, 2023, MDH had not submitted a report.

- ***Report on HCBS Expansion:*** As of February 18, 2023, MDH had not submitted a report in response to narrative in the 2022 JCR.

- ***MCO Risk Corridor Settlements:*** Further discussion of the results of calendar 2020 through 2022 risk corridor arrangements made between MDH and MCOs can be found in the Fiscal 2023 budget section of this analysis.

- ***CFC Program and Community Options Waiver Financial and Registry Data:*** The first of four requested quarterly reports was submitted on September 15, 2022. However, the second and third reports due in November and February have not been provided. Further discussion of this report and the Community Options Waiver can be found in the budget analysis for MDH – Overview – M00.

- ***Rate Adjustments for Dental Services under Medicaid:*** As of February 18, 2023, MDH had not submitted a report.

- ***EID Program Eligibility Requirements:*** As of February 18, 2023, MDH had not submitted a report.

Appendix 2
Medicaid Management Information System (MMIS) II, Also Known as the Medicaid Enterprise Systems Modular Transformation
Major Information Technology Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: July 1, 2016				**Est. Completion Date:** September 30, 2027				
Implementation Strategy: Agile								
($ in Millions)	**Prior Year**	**2023**	**2024**	**2025**	**2026**	**2027**	**Remainder**	**Total**
GF	$27.545	$19.143	$17.500	$27.541	$12.928	$20.589	$0.000	$125.246
FF	196.738	118.445	198.769	148.442	58.893	110.714	0.000	832.002
Total	**$224.283**	**$137.588**	**$216.269**	**$175.984**	**$71.821**	**$131.303**	**$0.000**	**$957.248**

Note: Numbers may not sum to total due to rounding.

- ***Project Summary*:** This IT project replaces Medicaid's antiquated and inflexible legacy information system with a modern MMIS. MDH has completed a Medicaid IT Architecture self-assessment of its business operations and subsequently developed a roadmap for procurement, replacement, and implementation of various modular systems, including:

  - Business Process Reengineering (formerly referred to as Customer Relationship Management);
  - Decision Support System/Data Warehouse;
  - Pharmacy Point-of-sale Electronic Claims Management System;
  - Behavioral Health Administrative Service Organization (BHASO);
  - TierPoint Migration of the Electronic Data Interchange Transaction Processing System;
  - eMedicaid migration to the Maryland Total Human-services Information Network (MD THINK);
  - No Wrong Door project integrating application transfers between Maryland Health Connection and eligibility and enrollment;
  - Nonemergency Medical Transportation; and
  - other business processes, such as provider and financial management, enterprise security, surveillance and utilization reviews, and core MMIS services.

- ***Need:*** The legacy MMIS was installed in 1995 and is unable to meet the needs of Maryland's increasingly complex Medicaid program. Three key goals of the new modular systems are (1) real-time and automated adjudication of claims (part of core MMIS implementation); (2) a new financial management system to automate the federal fund claims process; and (3) improved reporting capability. MDH will also integrate services through the MD THINK cloud-based platform as applicable.

- ***Observations and Milestones:*** MDH released a revised roadmap outlining the systems to be modernized and timeline for the project in July 2022 at the same time that planning documents were submitted to CMS for annual approval. Under the new roadmap, there will be three phases, and project completion has been pushed out from calendar 2025 to 2027. Of 11 modules included in this project, MDH reported that 9 were on track, with only 1 behind schedule and the remaining module in a pre-planning phase.

- ***Changes:*** The BHASO component went live January 2020, with limited functionality and resulted in significant provider payment issues that will take several years to resolve. MDH was working with Optum to complete development, manage defect releases, and develop a path to CMS certification but has since abandoned that effort due to security and health record privacy violations. Estimated federal fund spending for this project has increased substantially, by $172.0 million in federal funds, or 26%, in the 2023 session compared to estimated federal fund costs in the 2022 session. This spending increase coincides with the project being rebased as an updated roadmap was recently issued. Anticipated general fund spending decreases by $4.2 million in the 2023 session estimate compared to the prior year.

- ***Concerns:*** The BHASO module go-live was a complete failure, with defects continuing to be resolved. Further discussion of the difficulties with the BHASO transition can be found in the analysis for MDH BHA – M00L. A new roadmap and timeline have been necessary after the COVID-19 pandemic further delayed procurements and work on some modules. Despite these concerns, MDH and the Department of Information Technology did not identify any high-risk components of the project.

- ***Other Comments:*** CMS may approve 90% federal financial participation for design, development, or installation of MMIS costs. MDH completed the required assessment and documentation to receive enhanced federal fund participation for eligible expenses under the MMIS II project. The current budget reflects a federal fund participation rate of 86.9%, likely due to some share of planned costs supporting other uses that receive a slightly lower federal matching rate, such as maintenance expenses.

Appendix 3
Long Term Services and Supports Tracking System
Major Information Technology Project
Maryland Department of Health

New/Ongoing: Ongoing								
Start Date: July 1, 2020		**Est. Completion Date:** Final development anticipated for fiscal 2025						
Implementation Strategy: Waterfall and Agile mix								
($ in Millions)	**Prior Year**	**2023**	**2024**	**2025**	**2026**	**2027**	**Remainder**	**Total**
GF	$29.528	$5.393	$0.167	$3.514	$3.514	$5.408	$0.000	$47.526
FF	149.146	29.648	24.933	24.933	24.933	32.414	0.000	286.007
Total	**$178.675**	**$35.041**	**$25.101**	**$28.447**	**$28.447**	**$37.821**	**$0.000**	**$333.533**

Note: Numbers may not sum to total due to rounding.

- ***Project Summary:*** The LTSS tracking system is an integrated care management system for long-term care services that includes a standardized assessment instrument, in-home services verification, and real-time medical and service information. Initially developed to respond to various long-term care program opportunities under the ACA, LTSS has been incorporating other modules to cover all HCBS under Medicaid, including services to the developmentally disabled.

- ***Need:*** This IT project integrates many common functions across HCBS programs and allows the State to meet federal requirements for electronic visit verification (EVV) of personal care services.

- ***Observations and Milestones:*** As of July 2022, CMS had certified LTSS EVV functions for Medicaid waivers administered by DDA. This brings Maryland into compliance with the federal Twenty First Century Cures Act for those waivers, although MDH has not completed EVV functionality for the Waiver for Children with Autism Spectrum Disorder (anticipated late calendar 2022) and the Model Waiver for Disabled Children (anticipated in calendar 2023).

- ***Concerns:*** The highest risk for the LTSS project remains engagement with, and adoption by, stakeholder groups. MDH identified certain factors as medium-risk, such as resource availability related to staffing, interdependencies with stakeholder activities, technical risks such as improper testing prior to launch, and implementation of corrective actions when defects are found.

- ***Other Comments:*** MDH received approval for enhanced federal financial participation for certain costs associated with this project. The department anticipates that this higher federal share of costs will continue through the life of this project as fiscal 2027 projected costs are budgeted with an 85.7% federal matching rate.

Appendix 4
Federal Poverty Guidelines as of January 19, 2023
(48 Contiguous States and the District of Columbia, Excluding Alaska and Hawaii)

Household/ Family Size	25%	50%	75%	100%	125%	133%	135%	138%[1]	200%	212%	250%	264%[2]	322%[3]
1	$3,645	$7,290	$10,935	$14,580	$18,225	$19,391	$19,683	$20,120	$29,160	$30,910	$36,450	$38,491	$46,948
2	4,930	9,860	14,790	19,720	24,650	26,228	26,622	27,214	39,440	41,806	49,300	52,061	63,498
3	6,215	12,430	18,645	24,860	31,075	33,064	33,561	34,307	49,720	52,703	62,150	65,630	80,049
4	7,500	15,000	22,500	30,000	37,500	39,900	40,500	41,400	60,000	63,600	75,000	79,200	96,600
5	8,785	17,570	26,355	35,140	43,925	46,736	47,439	48,493	70,280	74,497	87,850	92,770	113,151
6	10,070	20,140	30,210	40,280	50,350	53,572	54,378	55,586	80,560	85,394	100,700	106,339	129,702
7	11,355	22,710	34,065	45,420	56,775	60,409	61,317	62,680	90,840	96,290	113,550	119,909	146,252
8	12,640	25,280	37,920	50,560	63,200	67,245	68,256	69,773	101,120	107,187	126,400	133,478	162,803
9	13,925	27,850	41,775	55,700	69,625	74,081	75,195	76,866	111,400	118,084	139,250	147,048	179,354
10	15,210	30,420	45,630	60,840	76,050	80,917	82,134	83,959	121,680	128,981	152,100	160,618	195,905
11	16,495	32,990	49,485	65,980	82,475	87,753	89,073	91,052	131,960	139,878	164,950	174,187	212,456
12	17,780	35,560	53,340	71,120	88,900	94,590	96,012	98,146	142,240	150,774	177,800	187,757	229,006
13	19,065	38,130	57,195	76,260	95,325	101,426	102,951	105,239	152,520	161,671	190,650	201,326	245,557
14	20,350	40,700	61,050	81,400	101,750	108,262	109,890	112,332	162,800	172,568	203,500	214,896	262,108

[1] The ACA expanded Medicaid coverage to individuals with household incomes below 138% of the FPL.
[2] Pregnant women can have higher household incomes and still qualify for Medicaid. The income eligibility threshold for pregnant women is 264% of FPL.
[3] The income eligibility threshold for children enrolled in MCHP is 322% of FPL. MCHP participants with household incomes above 212% are required to pay monthly premiums, though premiums have been suspended during the national COVID-19 PHE.

Source: U.S. Department of Health and Human Services; Department of Legislative Services

Appendix 5
Object/Fund Difference Report
Maryland Department of Health – Medical Care Programs Administration

Object/Fund	FY 22 Actual	FY 23 Working Appropriation	FY 24 Allowance	FY 23 - FY 24 Amount Change	Percent Change
Positions					
01 Regular	618.00	608.00	619.00	11.00	1.8%
02 Contractual	83.05	114.83	170.80	55.97	48.7%
Total Positions	**701.05**	**722.83**	**789.80**	**66.97**	**9.3%**
Objects					
01 Salaries and Wages	$ 55,824,164	$ 61,094,717	$ 65,265,839	$ 4,171,122	6.8%
02 Technical and Special Fees	5,339,864	7,301,780	10,000,159	2,698,379	37.0%
03 Communication	865,990	867,240	935,355	68,115	7.9%
04 Travel	48,435	208,820	373,922	165,102	79.1%
06 Fuel and Utilities	5,721	7,049	6,049	-1,000	-14.2%
07 Motor Vehicles	0	2,438	0	-2,438	-100.0%
08 Contractual Services	11,698,041,564	12,186,639,376	12,494,727,838	308,088,462	2.5%
09 Supplies and Materials	184,218	194,338	193,144	-1,194	-0.6%
10 Equipment – Replacement	112,637	104,568	198,526	93,958	89.9%
11 Equipment – Additional	0	2,200	0	-2,200	-100.0%
13 Fixed Charges	221,800	265,437	368,953	103,516	39.0%
Total Objects	**$11,760,644,393**	**$ 12,256,687,963**	**$ 12,572,069,785**	**$ 315,381,822**	**2.6%**
Funds					
01 General Fund	$ 3,313,865,319	$ 4,013,997,047	$ 4,288,455,642	$ 274,458,595	6.8%
03 Special Fund	707,865,524	755,086,485	720,612,797	-34,473,688	-4.6%
05 Federal Fund	7,651,871,836	7,405,202,969	7,473,498,601	68,295,632	0.9%
09 Reimbursable Fund	87,041,714	82,401,462	89,502,745	7,101,283	8.6%
Total Funds	**$11,760,644,393**	**$ 12,256,687,963**	**$ 12,572,069,785**	**$ 315,381,822**	**2.6%**

Note: The fiscal 2023 appropriation does not include deficiencies or planned reversions. The fiscal 2024 allowance does not include salary adjustments that are budgeted in the Statewide Account within DBM or contingent reductions.

Appendix 6
Fiscal Summary
Maryland Department of Health – Medical Care Programs Administration

Program/Unit	FY 22 Actual	FY 23 Wrk Approp	FY 24 Allowance	Change	FY 23 – FY 24 % Change
01 Deputy Secretary for Health Care Financing	$ 11,175,295	$ 81,712,921	$ 31,660,166	-$ 50,052,755	-61.3%
02 Enterprise Technology – Medicaid	15,501,520	15,990,938	19,588,655	3,597,717	22.5%
03 Medical Care Provider Reimbursements	11,282,769,130	11,630,384,550	11,887,877,518	257,492,968	2.2%
04 Office of Health Services	55,561,831	48,778,631	71,915,272	23,136,641	47.4%
05 Office of Finance	7,230,531	8,053,248	8,628,704	575,456	7.1%
07 Maryland Children's Health Program	305,284,212	295,714,680	300,895,776	5,181,096	1.8%
08 Major Information Technology Development	58,578,387	148,182,482	223,702,411	75,519,929	51.0%
09 Office of Eligibility Services	14,078,711	15,818,031	16,788,240	970,209	6.1%
11 Senior Prescription Drug Assistance Program	10,464,776	12,052,482	11,013,043	-1,039,439	-8.6%
Total Expenditures	**$11,760,644,393**	**$12,256,687,963**	**$12,572,069,785**	**$ 315,381,822**	**2.6%**
General Fund	$ 3,313,865,319	$ 4,013,997,047	$ 4,288,455,642	$ 274,458,595	6.8%
Special Fund	707,865,524	755,086,485	720,612,797	-34,473,688	-4.6%
Federal Fund	7,651,871,836	7,405,202,969	7,473,498,601	68,295,632	0.9%
Total Appropriations	**$11,673,602,679**	**$12,174,286,501**	**$12,482,567,040**	**$ 308,280,539**	**2.5%**
Reimbursable Fund	$ 87,041,714	$ 82,401,462	$ 89,502,745	$ 7,101,283	8.6%
Total Funds	**$11,760,644,393**	**$12,256,687,963**	**$12,572,069,785**	**$ 315,381,822**	**2.6%**

Note: The fiscal 2023 appropriation does not include deficiencies or planned reversions. The fiscal 2024 allowance does not include salary adjustments that are budgeted in the Statewide Account within DBM or contingent reductions.